The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XXXV, No. 1 January, 1952

TABLE OF CONTENTS

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXV JANUARY, 1952 NO. 1

WHO SEES THE PSYCHIATRIST?*

LAURENCE A. SENSEMAN, M.D.

The Author. *Laurence A. Senseman, M.D., of Lincoln, R. I.; Chief, Neuro-Psychiatry, Memorial Hospital, Pawtucket, R. I.; Medical Director, Fuller Memorial Sanitarium, South Attleboro, Mass.*

TODAY, Psychiatry, as a specialty of medicine, is in the limelight. There is an ever increasing interest in this subject among lay persons as well as the medical profession. The radio, TV, in the press, in popular magazines there is an ever increasing volume of material available regarding psychiatric patients and psychiatry in general. Some of this is true and some of it is pure fiction; some has an element of truth which cannot be denied. It has also been the subject of many jokes and humor, all of which only emphasizes its importance in the public mind.

There is no question regarding the magnitude of the problem of mental illness in the world today and in particular in our own way of life here in the United States. At the present time, approximately 50% of all hospital beds in this country are occupied by neuropsychiatric patients yet there are less than 5% of the physicians in the U.S.A. responsible for this high in-patient load. Compare with this, the large number of patients needing emotional help who see their family physician, members of the clergy or close friends and would-be psychiatrists; the number is tremendously increased. With the increase in the dissemination of knowledge regarding psychiatry there is an increase in the responsibility on the part of the psychiatrist; an ever growing need for public enlightenment regarding the principles of mental hygiene with prevention of mental illness and also its limitations. An excellent job is being done by the National Association for Mental Health, Inc. through press, radio, film and literature. Various state societies, including our own, have a definite program yet their funds are limited and they do not have the adequate support of lay and professional groups, so necessary to accomplish the tremendous task which needs to be done.

*Presented at the John F. Kenney Memorial Clinic, at the Memorial Hospital, Pawtucket, R.I., October 31, 1951.

†*Digest of Neurology and Psychiatry*, June, 1950; Series XVIII.

There is, however, an encouraging aspect to this problem and that is the fact that the qualified psychiatrist is being recognized by his medical colleagues as part of the team in assisting the patient in recovery. The psychiatrist is a physician skilled in the recognition and treatment of the various personal and interpersonal ills of the patient; he is versed in the total reactions of the patient as related to his environment. Psychiatrists are on the staff of every good and well recognized hospital; they are consultants on the various services and in the out-patient departments. Many city and university hospitals are now accepting for treatment early cases of mental illness. This new approach will prevent many patients from being committed to the mental hospital by the application of the newer forms of treatment which have revolutionized the whole practice of psychiatry.

This new acceptance of the psychiatrist by his fellow practitioners and their acceptance of the advice and opinion regarding the emotional aspects of the patient's illness, is, indeed encouraging. More and more of the physicians are taking advantage of the services of a psychiatrist when confronted with a difficult situation which does not respond to ordinary treatment.

From a recent editorial by the late Dr. C. C. Burlingame† I quote, "there is no such thing as a purely organic disease and no such thing as a purely psychogenic disease; there are elements of both in all disease. In recent years the advancement made in psychosomatic medicine has been phenomenal. You can no longer separate the mind from the body and thus the psychiatrist becomes more and more a part of the medical team in the treatment of those who are ill."

The purpose of this paper is to briefly analyze those seen by the psychiatrist and what disposition has been made of them after being seen. Recently, I made a survey of 250 consecutive new patients coming under my care. This study revealed some very interesting facts and answered a number of questions which have been asked in my office a number of times.

A lady who was seen in my office said, "Doctor, there is a man in your waiting room. I didn't know

continued on next page

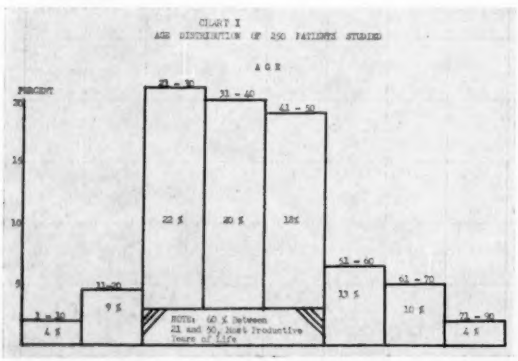
that psychiatrists take care of men." The idea that women are seen most frequently in the psychiatrist's office is quite prevalent. The fact is, that of the 250 patients in this series about 50% were men. Many people have the idea that only patients mentally ill are seen by the psychiatrists and hence they are reluctant to be seen in a psychiatrist's office. The figures which I will present from my records will, I believe, disprove this erroneous concept.

Another patient had come to my office for the first time and on looking about the office said, "Doctor, I didn't know that psychiatrists examined patients. I see you have an examining table in your office." This, too, is a prevalent idea that some patients have regarding the psychiatrist.

We as psychiatrists always give as complete a physical examination as possible to rule out the presence of any organic disease. Many times patients have been referred to me for nervous illnesses and on physical examination an organic illness has been found. The complete physical examination is just as much a part of a psychiatrist's armamentarium as it is for the internist or any other specialist. Laboratory procedures are also extremely helpful in establishing a diagnosis and should be used as frequently as in other specialties of medicine.

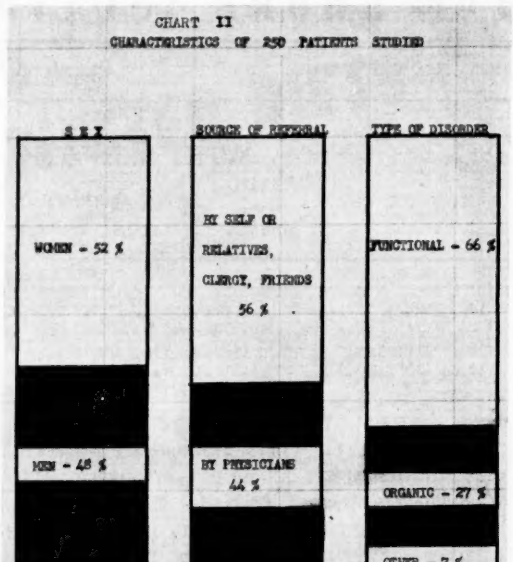
Now let us examine what this study of 250 new patients showed.

You will note that the largest group of these patients are found between the ages of 21-50 or 60%. This is the most productive period of life. The largest single group of patients in any decade were between 21-30, 54 patients. Early recognition of mental illness and early treatment, as in any other



illness enhances recovery of a larger percent of patients. No attempt has been made in this paper to prove this latter point.

Of the 250 new patients seen in this study it is interesting to note that 129 or 52% were women and 121 or 48% were men, so about the same number of women as men were treated. A look at who referred patients to the psychiatrist reveals that 114 or 44% were referred by other physicians while



136 or 56% came of their own volition or were referred by their friends, members of the clergy or former patients. All but 24 of all these patients were seen in my office and of these 24, 7 were seen at home, 16 in the hospital on consultation and 1 at the police station.

Now let us look at the type of basic disorder that these 250 patients presented. Two of every three were treated for functional problems while most of the rest had neurological problems.

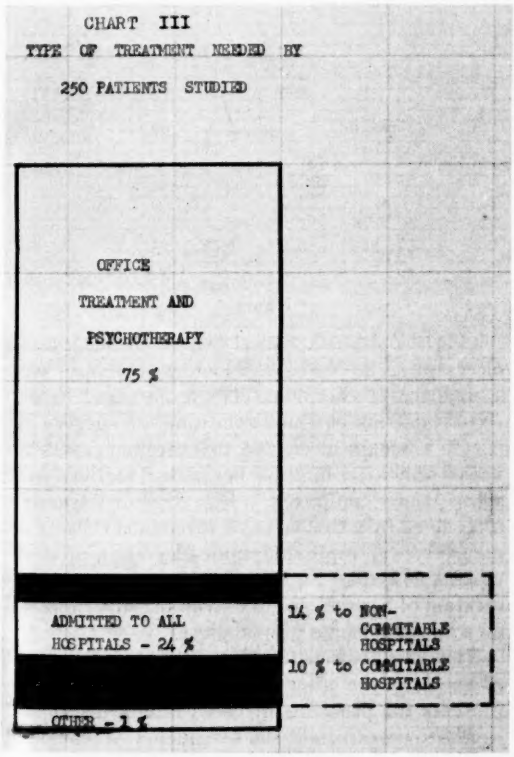
Functional Problems

Depressed Reactions	36
Anxiety Neurosis	23
Psychoneurosis	28
Nervous reactions with Emotional Maladjustment	28
Schizophrenia	11
Hysteria	7
Psychosomatic Problems	5
Alcoholics	5
Nervous reaction with Menopause	5
Mental Deficiency	4
Paranoid reaction	3
Senile Psychosis	3
Obsessive Compulsive Neurosis	2
Psychopathic Personality	2
Hypomanic	1
Post-operative Psychosis	1
Undiagnosed Psychosis	1
Total	165 or 66%

Neurological Problems

Head Injuries	14
Convulsive disorders	11
Neuritis	9
Multiple Sclerosis	9
Senility with Arteriosclerosis	5
Brain Tumor	4
Alzheimer's Disease	4
Cerebral Vascular Accident	3
Meniere's Syndrome	1
Chorea	1
Herpes Zoster	1
Ruptured Disc	1
Pernicious Anemia with Cord changes	1
Encephalitis	1
Mongoloid child	1
Total	67
	or 27%
Examined without CNS disease	11
Neurological examinations	7
Total	18
	or 7%

Grand Total 250



Everyone thinks that only the serious, mentally ill patients visit a psychiatrist's office. That the contrary is true is most effectively shown in Chart III which shows that three out of every four of the 250 patients treated required only office treatment and psychotherapy. Twenty-four per cent were hospitalized, 14% to non-committable hospitals, 6% were committed and only 4% were committed to the State Hospital.

Typical Case Fe. Age: 58

Symptoms and complaints:

"My stomach bothers me, very, very bad and I have been very nervous for years. My head pains just like the nerves are jumping and the nerves all over my body twitch. I'm always just this side of being nauseated and have hot feelings rush up into my face. It is just like a toothache in my head. It seems as though my stomach is affected by my head or vice versa. I have a lot of gas. There is a prickling feeling about my lips. I used to take walks but now I am unable to walk. I have not been eating well lately. This feeling about the heart makes me think there is some heart trouble. My face is sensitive to cold air. All my teeth should come out but I feel I'm too bad to go through with it. I sleep poorly unless I take a capsule. I awaken in the a.m. very shaky. I cry at times and I've always been of a nervous makeup. This dizziness licks me. My mother died of Ca of the stomach but this doesn't worry me. I took care of her at the time. Some times she too lost her courage. I have a fear of insanity and feelings of unreality. I'm depressed and discouraged most of the time. 'Have you lost the joy of living?' Well, I find no real joy in living this way, nothing can help me.' "

This patient proved to have a depression which was masked by these multiple autonomic nervous system complaints. Later she was treated with electric convulsive therapy and made a good recovery.

Our minds and our emotions are just as much a part of us as our physical bodies. More and more people are understanding that to see a psychiatrist doesn't necessarily mean insanity. It could well be that if people were less hesitant about discussing emotional problems with the psychiatrist this in itself could act as a safeguard against some more serious disorder.

I quote again from Dr. Burlingame's article. "To correct the impression that a psychiatrist is a man of words alone we must emphasize that we know the human body, we understand its mechanisms and that we have more than just a speaking acquaintance with bodily disease processes."

At the present time, we are living in a swift moving, scientific world and it is extremely difficult for any one person to keep up with the many advances in each specialty. Psychiatry is a broad field, it projects its interest into all specialties, and more and more as the basic concepts of psychiatry are used and understood by all specialists and the general practitioner, it will aid in the psychological ap-

continued on page 24

GASTRIC ULCER AND GASTRIC CARCINOMA*

— *A Review of the Experience at the Providence Veterans Hospital* —

PHILIP COOPER, M.D. AND THOMAS F. FITZGERALD, M.D.

The Authors. *Philip Cooper, M.D., Chief, Surgical Service, and Thomas F. FitzGerald, M.D., Assistant Chief, Surgical Service, U.S. Veterans Administration Hospital, Providence, R. I.*

THE RESULTS of the present treatment of carcinoma of the stomach are not very encouraging. The death rate from carcinoma of the stomach is approximately 25 to 40 per cent of all deaths from cancer. That means that approximately 40,000 deaths each year are the direct result of carcinoma of the stomach.

The interpretation of the results of the treatment of this disease must take into consideration the total number of cases of carcinoma of the stomach presenting themselves for treatment to a specific institution. In addition one must be aware of some selection of cases that may exist at a specific clinic or hospital. Five year survivals based on total cases seen, vary from 2 to 8 per cent. The resectability rate will be greatly determined by the degree and type of selection of cases, as well as by the technical ability and perspective of the surgical staff. Lahey and Marshall[3] report a 25 per cent, and Pack, according to Adair[2], a 47 per cent resectability rate. Their five year survival rate after resection are 22.3 per cent and 35 per cent respectively. Many clinics do not report as good results.

It is obvious that at some time every gastric carcinoma could be successfully resected. The poor results of treatment are due on many occasions to a delay by the patient in reporting to his physician and, on other occasions, to the delay by the physician in initiating proper therapy. This problem is due to some extent to the difficulty in the differential diagnosis between the benign and the malignant gastric ulcer.

It is probable that some chronic gastric ulcers do become malignant, and that some carcinomas do have secondary peptic ulcerations. Mallory[5] showed that peptic ulceration superimposed on a superficial carcinoma can give one the impression of an early carcinoma superimposed on a benign gastric ulcer. Warren, according to Jordan,[6] believes that "with repeated healing, and ulceration, the cells undergo changes which transform them into malignant cells." Others have varying opinions on the subject.

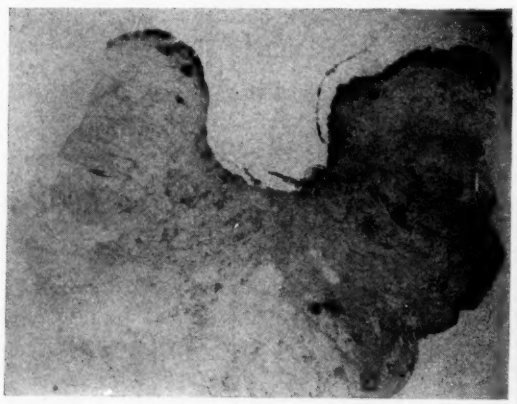


Figure 1

(Fig. 1) shows a typical benign chronic gastric ulcer. (Fig. 2) shows a chronic gastric ulcer with a small area of carcinoma cells at one edge. Frozen section on this patient at the time of surgery reported a benign ulcer, and this carcinoma was revealed only after multiple permanent sections were subsequently completed. (Fig. 3) shows a gastric ulcer lined by a thin layer of carcinoma cells. This may very well represent peptic ulceration of a carcinoma whereas (Fig. 2) may represent peptic ulceration of a carcinoma or carcinoma superimposed on a chronic benign gastric ulcer.

The difficulty in determining the proper sequence of events in the latter two slides is obvious, and it presents the problems involved in any determination as to the possibility and frequency of malignant transformation of benign gastric ulcer.

The greatest difficulty in differentiating between a benign and a malignant ulcerating lesion of the stomach is with the malignant ulcer which grossly resembles the benign ulcer of the stomach. The

*Presented at the Fourth Annual Cancer Conference for Rhode Island Physicians, at Providence, R.I., October 17, 1951.

Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

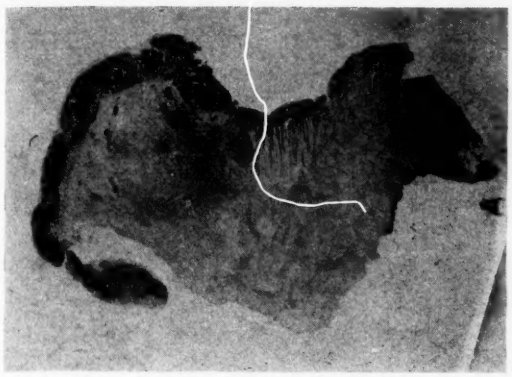


Figure 2

polypoid, infiltrating and the typical ulcerating cancers do not present a great problem in diagnosis. In this paper we are referring mainly to the benign gastric ulcer and the malignant gastric ulcer which anatomically resembles it.

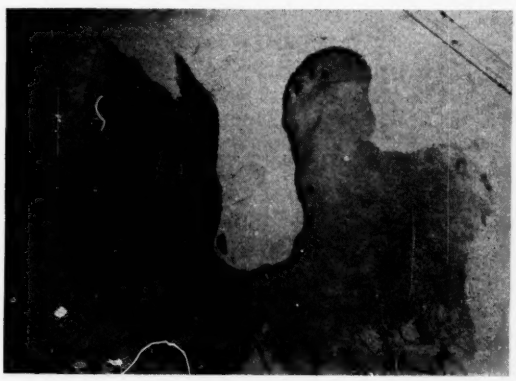


Figure 3

Both lesions can produce essentially the same symptomatology. A long history of ulcer dyspepsia has been obtained frequently in patients with carcinoma. Walters[7] has shown that 33 per cent of patients with carcinoma of the stomach presented an ulcer type of dyspepsia, and Lampert et al[8] found in a review of malignant ulcers that the onset of symptoms prior to surgery averaged 38 months, and that an ulcer type of dyspepsia prior to surgery had been present up to 40 years.

Carcinoma of the stomach has been found in the third decade and on rare occasions in the second decade of life, although basically it is a disease of older people.

The examination by the roentgenologist is of great value. Certain areas in the stomach such as the prepyloric, greater curvature, and fundus regions are more prone to malignancy, whereas the middle of the lesser curvature and the pyloric valve regions are more likely to develop benign ulcerations. These facts, however, have only statistical value.

Gastroscopy has its limitations because of the so-called "blind" areas and because of the fact that a cancer may have the gross appearance of a benign ulcer. Gastroscopy may be of great value when the existence of an ulcer is suspected but cannot be demonstrated by X-ray examination.

Achlorhydria after histamine strongly suggests the presence of a malignant ulcer. However, Heffernan et al[9] have reported two cases, and we have had two cases of benign gastric ulcer with achlorhydria after histamine. The degree of gastric acidity is of no value in differential diagnosis.

Microscopic examination of the gastric sediment has been employed. This method is of value only if attention is paid to all details in the method of collection and preparation of the specimen. A negative examination, however, will not rule out the presence of a cancer of the stomach.

In spite of careful preoperative studies, approximately ten per cent of gastric ulcers thought to be benign preoperatively prove, after surgery, to be malignant. Actually the pathologist may give the wrong diagnosis if a frozen section of the ulcer is not accomplished. The frozen section examination, also, may be inadequate.

It is obvious then that there are no means by which a positive diagnosis of a benign ulcer can be made except by the examination of multiple microscopic sections of the ulcer.

We all recognize the fact that the proper treatment of a carcinoma of the stomach is resection, if possible. In view of the difficulty in differential diagnosis between a benign and a malignant ulcer the advisability of resecting all ulcerations of the stomach must be most seriously considered.

It has been suggested by many that gastric ulcer is fundamentally a surgical disease, yet in general, they feel that "conservative" treatment may be indicated, with definite restrictions, in the younger age group. Welch[1] stated that "hospital observation and medical treatment for a three week period are warranted if the patient is young, with an ulcer of short duration, and the ulcer is on the lesser curvature and is small."

If a gastric ulcer is treated conservatively in young or old, and the lesion appears healed by the usual established criteria, we still have no assurance that we are not dealing with a malignant ulcer that has undergone secondary acute ulceration and healing. Careful follow-up on that patient may be too late in detecting definite evidence of carcinoma to accomplish a satisfactory resection.

In view of the fact that the only diagnostic criterium that can be totally relied upon is that based on microscopic examination of the ulcer, we at the V.A. Hospital in Providence, are promptly refer-

continued on next page

ring all proven gastric ulcerations to the surgical service for operation.

We are in a fortunate position in the stomach "ulcer-cancer" problem in that if we resect a benign gastric ulcer because of possible malignancy, and find the ulcer to be benign we actually have given that patient an excellent form of therapy. The medical treatment of benign gastric ulcers, in general, has not been too satisfactory. They have a marked tendency to recur, and a greater tendency than duodenal ulcers to perforate or bleed. At the Mayo Clinic, Kiernan[10] reported 50 per cent of the patients treated for gastric ulcer were dissatisfied with medical treatment. Doll[11] showed that after suture of a perforated ulcer 50 per cent of the cases had severe relapses, and 20 per cent had further major complications. Jordan[6] has stated that "ulcer statistics grow worse rather than better as time goes on and ulcer patients live on."

Surgical therapy for gastric ulcer has been most encouraging. Walters[12] and Marshall[13] have shown that a benign gastric ulcer will not recur, nor will a gastrojejunal ulcer develop, after gastrectomy has been accomplished. The mortality for gastrectomy, in capable hands, for benign gastric ulcer is now between 1 and 2 per cent.

At the Providence V.A. Hospital from July 1, 1949 to September 1, 1951, 33 gastrectomies have been accomplished for benign gastric ulcer. Table I presents the preoperative clinical findings on the 33 gastric ulcers that proved to be benign. The problems involved in gastrectomy are demonstrated by the reported findings of that examination.

TABLE I

1. Total—33; Age—32 to 71 Years
2. Ulcer Dyspepsia—23; Duration 6 Mos. to 31 Years
3. G. I. Bleeding—13
4. History of Perforated Ulcer—4
5. Weight Loss—0 to 45 Lbs.
6. Gastric Analysis—16; No F.F.A. after Histamine—2
7. Gastrectomy—8
   a. Gastric Ulcer—2
   b. Possible Malignant Ulcer—1
   c. Hypertrophic Gastritis—1
   d. Negative—4

Table II shows the difficulties involved in the preoperative evaluation of these patients.

TABLE II

8. Preoperative Diagnosis
   Gastric Ulcer—18
   Gastric Ulcer, Possibly Ca—5
   Duodenal Ulcer—6
   Duodenal Ulcer, Possible Gastric—1
   Extramucosal Tumor—1
   Ca of Stomach—1
   Pyloric Obstruction—1

Table III shows the operative procedures and the pathology on the benign gastric ulcer group. The only complications were two wound disruptions on two very obese individuals. One of the patients entered the hospital with a perforation of the ulcer. This was repaired, and subsequently a subtotal gastrectomy was accomplished. There was no mortality in this group.

TABLE III

9. Operative Procedures—36
   a. Subtotal Gastrectomy—33
   b. Gastroenterostomy—0
   c. Suture of Perforation—1
   d. Repair of Wound Disruption—2
10. Mortality—0%
11. Pathology
   a. Benign Gastric Ulcer—24
   b. Combined Gastric and Duodenal Ulcers—6
   c. Pyloric Ulcers—3

Table IV reveals no recurrence of ulcer symptoms, or peptic ulceration by X-ray, in the follow-up studies.

There were 23 patients with carcinoma of the stomach admitted to the Providence V.A. Hospital between July 1, 1949 to September 1, 1951.

TABLE IV

12. Follow-Up—33
   a. Duration Postop—2 Mos. to 25 Mos.
   b. Present Status
   (1) No Recurrence of Symptoms—0
   (2) Recurrent Ulcer by X-Ray—0

GASTRIC CARCINOMA
Veterans Administration Hospital
Providence 8, Rhode Island
July 1, 1949 to Sept. 1, 1951

Table V reveals the youngest patient to be 30 years of age. In this group, ulcer dyspepsia was present up to 32 years. There were eight inoperable cases. Four of those patients had been operated upon elsewhere, and had developed extensive recurrence of their disease with metastases, which contra-indicatd further surgery. The other four patients were considered inoperable because of the presence of metastases. Fifteen patients were operated upon.

TABLE V

1. Total—23; Age—30 to 70 Years
2. Ulcer Dyspepsia—11; Duration 9 Mos. to 32 Yrs.
3. G. I. Bleeding—9
4. History of Perforation—3
5. Weight Loss—0 to 60 Lbs.
6. Gastric Analysis—7; No F.F.A. after Histamine—1
7. Total—23
   Inoperable—8
   Operable—15
8. Inoperable—8
   a. Previous Surgery—4
      (1) Esophogastrectomy—2
      (2) Exploratory Laparotomy—1
      (3) Repair of Perforation and Gastroenterostomy—1
   b. No Previous Surgery—4

In Table VI the preoperative diagnoses are listed. It is of interest that five patients were operated upon with a preoperative diagnosis of benign gastric ulcer, and one with a preoperative diagnosis of benign gastric ulcer possibly carcinoma.

TABLE VI

11. Preoperative Diagnosis—15
    a. Benign Gastric Ulcer, ? of Ca—1
    b. Benign Gastric Ulcer—5
    c. Ca of Stomach—7
    d. Ca of Stomach with Gastrocolic Fistula—1
    e. Abdominal Carcinomatosis with Large Bowel Obstruction—1

In Table VII the operations performed are listed. The cecostomy, gastroenterostomy, and cholecystojejunostomy were obviously palliative procedures. One patient had both a subtotal followed by a total gastrectomy when the permanent microscopic sections revealed a lesion to be malignant.

TABLE VII

9. Operable—15
10. Operations Performed—16
    a. Total Gastrectomy—2
        (1) Palliative—0
        (2) For Cure—2
    b. Subtotal Gastrectomy—6
        (1) Palliative—0
        (2) For Cure—6
    c. Exploration and Biopsy—5
    d. Cecostomy—1
    e. Gastroenterostomy—1
    f. Cholecystojejunostomy—1

Table VIII shows the pathology found on the operable cases. The diagnosis of "chronic lymphadenitis" resulted from an unsatisfactory biopsy. The patient had an obvious nonresectable lesion.

TABLE VIII

12. Pathology, Operable Cases—15
    a. Adenocarcinoma—11
    b. Carcinoma Simplex—1
    c. Reticulum Cell Sarcoma—1
    d. Chronic Lymphadenitis—1
    e. Linitis Plastica, Ca—1
    Resectable Lesions for Cure—7
    a. Negative Lymph Nodes—4
    b. Positive Lymph Nodes—3

Table IX shows the figures on postoperative mortality.

TABLE IX

13. Postoperative Mortality
    Operations—16
    a. Gastroenterostomy—1, 33 days
    b. Cecostomy—1, 12 days
    c. Biopsy—2, 22 days

Table X shows the follow-up studies on the patients in the surgical survival group.

This series of carcinoma cases is too small for general statistical purposes, yet it gives one indications as to the pathetic situation confronting us in the treatment of carcinoma of the stomach.

TABLE X

14. Follow-Up; 11 Surgical Survivals

a. Resection for Cure	Total—2	Subtotal—5
Duration Postop	15 Mos.	10-12 Mos.
Living	1	3
Dead	0	1
No Reply	1	1

    b. Cholecystojejunostomy—1
        Dead—6 Mos.
    c. Biopsies—3
        Living 1—13 Mos.
        Dead 2—5 and 6 Mos.

There were twenty-three patients wtih carcinoma of the stomach admitted to the hospital. Seven resections for "cure" were accomplished. Four of the inoperable cases were patients sent to us for terminal care, surgery having been accomplished elsewhere.

So far the resection cases, in general, have been doing well. The one death in the post resection group was not due to carcinoma, as far as could be determined.

It is not felt that any of these follow-up figures should be presented on a percentage basis because of the relatively short follow-up period. However, in general, the figures are fairly consistent with reports on larger series.

It is appreciated that this series is limited, yet it well demonstrates many of the problems involved. We must remember that five year survivals for gastric carcinoma after resection are doubled if the patient is operated upon with a preoperative diagnosis of benign ulcer[8].

It appears, at this time, that the reasonable approach to the problems of gastric carcinoma is to operate on all gastric ulcerations without a period of so-called conservative management.

Vagotomy for gastric ulcer is contra-indicated both because of the unsatisfactory results as reported by Dragstedt et al[14] and the great danger of leaving a malignant lesion undisturbed.

In general the suggested operation for carcinoma of the stomach is a radical subtotal gastrectomy with removal of the gastro-hepatic, and the greater omentum, part of the duodenum, and approximately two inches of stomach proximal to the lesion. The line of section should be examined by frozen section. Lahey[4] and Longmire[15] feel that total gastrectomy should be performed more frequently for carcinoma, and that such a procedure will offer a better five year survival rate after resection. Further follow-up studies will obviously be necessary to fully evaluate the feasibility of accomplishing total gastrectomy for all carcinomas of the stomach.

Summary

(1) A report of surgery for benign gastric ulcer and for gastric carcinoma at the Providence V.A. Hospital has been presented.

continued on next page

(2) The problems involved in the differential diagnosis of a benign and a malignant gastric ulcer are discussed.

(3) Prompt surgical treatment is recommended for all ulcerations of the stomach.

ADDENDUM

Gastric Ulcer and Gastric Carcinoma

Since completion of paper the two patients who had not replied to previous requests have replied.

The second patient with total gastrectomy for carcinoma died eleven months postoperatively.

The fifth patient with subtotal gastrectomy for carcinoma is living twenty-four months postoperatively, but has symptoms suggestive of recurrence of carcinoma.

BIBLIOGRAPHY

1 Welch, C. E. Carcinoma of the Stomach. Surg. Clin. of N.A., Oct., 1947.

2 Adair, F. E. The Past and Present of Cancer Therapy in the U.S.A. with a discussion of Therapeutic Results from the Memorial Hospital. Cancer is Curable. Symposium, Proceedings A.C.S., 34th Annual Clin. Congress, 1948.

3 Lahey, F. H. and Marshall, S. F. Should Total Gastrectomy be employed in early Carcinoma of the Stomach? Experience with 139 Total Gastrectomies.

4 Lahey, F. H. Total Gastrectomy for all Patients with Operable Cancer of the Stomach. S.G. & O., 90:246, Feb., 1950.

5 Mallory, T. B. Carcinoma in situ of the stomach and its bearing on the histogenesis of malignant ulcers. Arch. of Path. 30:348, 1950.

6 Jordan, Sara M. An evaluation of the peptic ulcer problem. Med. Annals of District of Columbia, Vol. 17, No. 6, June, 1948.

7 Walters, W. Gastric ulcer-carcinomatous ulcer or ulcerating carcinoma. Ann. Surg. 115:521, 1942.

8 Lampert, E. G., Waugh, J. M. and Dockerty, M. B. The incidence of malignancy in gastric ulcers believed preoperative to be benign. S.G. & O., 91:673, 1950.

9 Heffernan, E. W., Kiefer, E. D., and Tracey, M. L. Benign Gastric Ulcers occurring in the presence of achlorhydria; Report of Two Cases. N.E.J.M. 241:604, Oct. 20, 1949.

10 Kiernan, P. C. Gastric ulcer and its relation to malignancy. Surg. Clin. of N.A., Page 1743, Dec. 1950.

11 Doll, R. Perforated carcinoma of the stomach simulating perforated gastric ulcer. Brit. Med. Jour. 1:215, 1950.

12 Walters, W. Gastric ulcer, benign or malignant. Arch. of Surg. 44:520, 1942.

13 Marshall, S. F. Earlier operation for gastric ulcer. Lahey Clinic Bull. 7:2, July, 1950.

14 Dragsted et al. Recurrence of gastric ulcer after complete vagotomy. Ann. of Surg. 130:843, 1949.

15 Longmire, W. P., Jr. Total gastrectomy for carcinoma of the stomach. S.G. & O. 84:21, 1947.

WHO SEES THE PSYCHIATRIST?

continued from page 19

proach to the patients who come under the physician's care. Not that psychiatry has any more to offer than any other specialty nor has all the answers to these often difficult problems but in its broader aspects their concepts can be utilized in understanding our patients and ourselves and making our community a better place in which to live.

Conclusions

The figures I have presented would suggest that:

1. Patients seen by the psychiatrist are about evenly divided as far as sex is concerned. Men are just as likely to visit a psychiatrist's office as are women.
2. About ¾ of these patients have strictly functional disorders, the other ¼ have neurological or structural disease of C.N.S.
3. The largest percentage of these patients (60% of them) seen were between the ages of 21-50, the most productive years of life.
4. Most patients, 3 of every 4 of them, can be cared for by office visits.
5. Only 10% of the total number seen were committable and 4% were committed to the State Hospital for Mental Disease.

1952 Meetings Worth Noting

April 21-25 . . . American College of Physicians at Cleveland

April 29-30 . . . Connecticut State Medical Society at Hartford

May 6-7-8 . . . RHODE ISLAND MEDICAL SOCIETY at Providence

May 20-21-22 . . . Massachusetts Medical Society at Boston

June 9-13 . . . American Medical Association at Chicago

June 22-24 . . . Maine Medical Association at Rockland

September 2-5 . . . International College of Surgeons at Chicago

September 7-9 . . . New Hampshire-Vermont State Medical Societies at Bretton Woods, New Hampshire

September 22-26 . . . American College of Surgeons at New York

October 28-30 . . . N. E. Postgraduate Assembly at Boston

AMA DELEGATE'S REPORT

INTERIM SESSION OF THE AMERICAN MEDICAL ASSOCIATION

Los Angeles, California, December 3-7, 1951

CHARLES L. FARRELL, M.D., *Delegate*

THIS WAS ONE of the best attended Interim Sessions in several years. Your Delegate was kept very busy and did not have an opportunity to examine the scientific exhibits nor the commercial exhibits owing to the fact that he was appointed Chairman of the Reference Committee on Hygiene and Public Health which took up a considerable portion of his time not spent in the Meetings of the House.

A complete detailed report of House actions will be found in the *Journal* of American Medical Association. Highlights of the Session, though, are as follows:

PUBLIC FORUM

Senators Taft and Byrd spoke against Socialism and President Truman's policies at a public forum which was broadcast throughout the nation. Senator Taft criticized the Government's spending policy and the restriction of personal liberty in Washington bureaucracy. Senator Byrd also attacked the Welfare State. He called it socialism which never brought greatness, happiness or security to any nation.

The A.M.A. continued the services of Whitaker and Baxter at reduced outlay from 1951 level—reduced their services to part-time consultation basis.

HESS REPORT

The House of Delegates adopted a statement of policy regarding the physician-hospital relation as a change in the Hess Report. At the present time the House approves changes making *physicians alone* accountable for any changes of procedure. Prior to this there was a threat of disciplinary action against non-cooperating hospitals which provoked an adverse comment from A.M.A. legal counsel. A summary of the Hess Report as adopted at present reveals

1. The physician should not "dispose of his professional attainments or services to any hospital or institution under conditions whereby such services are resold."

2. If a hospital does not sell a physician's services, a financial arrangement between them may be placed on any reasonably satisfactory basis. A remuneration may thus be made for research, teaching, not only by hospitals, but by lay bodies, corporations, etc.

3. The specialties of anesthesiology, pathology, physical medicine and radiology are recognized as integral parts of the practice of Medicine. These specialties are the ones deeply involved in this report.

COMMITTEE ON HOSPITAL-PROFESSIONAL RELATIONS

A great deal of discussion revolved around the prepayment contracts of Blue Cross and Blue Shield and similar plans. In some instances these contracts overlap. The Blue Cross and Blue Shield have been urged, therefore, to write their contracts so that they will cover medical care in Blue Shield plans and hospital care in Blue Cross plans, exclusively.

It was again urgently recommended that every state and local society form a Committee on Hospital-Professional Relations to hear complaints on professional or economic relations between physicians and hospitals. The cooperation of state and local hospital associations was also urged and state medical associations and county medical societies should affect liaison with these organizations to settle the problems involving doctors and hospitals.

DEPENDENTS' MEDICAL CARE

A resolution was adopted as follows: "If, in the independent judgment of the Department of Defense and Congress, the welfare of our preparedness program requires that dependents of members of our armed forces receive medical care on a service basis, then the medical profession stands ready to provide such service through Blue Shield and other medical society sponsored plans." Dr. R. L. Novy of Michigan, who is a member of the Blue Shield Commission, introduced the above resolution and discussed the problem of medical care for the dependents of service men.

continued on next page

VETERANS' PROBLEMS

For many years the problem of Veterans' Care has been presented by Dr. Shoulders of Tennessee, a former President of A.M.A. At each session the House has defeated and rejected representations by Dr. Shoulders. At this last session the question of Government responsibility for non-service connected cases was again brought to the floor and it was once more suggested that the Government contract and pay for memberships involving health service plans to cover veterans with non-service connected disabilities who are unable to pay for their own medical care. This subject produced much further discussion in the Reference Committee. The House passed the recommendations of the Reference Committee, which was headed by Dr. Robins of Arkansas, that the Board of Trustees appoint a special committee to study the plan offered by Dr. Shoulders and any other ramifications of Veterans Medical Care. They are also to consult with hospitals regarding insurance for veterans and any other interested organizations.

MEDICAL RESEARCH

The House of Delegates also authorized the Board of Trustees to have a committee conduct a survey to reveal the sources of funds now available for research, the amount of free-time being donated to research, and the fields of medical research receiving funds and in what proportion. It was felt that previous studies have concentrated primarily on governmental grants and have ignored, for the most part, the contribution of free-time by scientists and gifts of private individuals.

CHIROPRACTIC

The Selective Service Act permitted chiropractic students to be placed on a par with medical students in regard to being deferred for military duty in order to continue professional studies. The American Medical Association states, "It has been scientifically demonstrated that Chiropractic is without merit as a healing art and there is no current need in the armed forces for graduates of schools offering such instruction."

DISTRIBUTION OF PHYSICIANS

The Council on Medical Service proposal that measures be taken to study the problem of distribution of physicians was approved by the House and the House has authorized the Council on Medical Service to proceed with plans for regional conferences in the southeastern and southcentral areas of the United States.

FLUORIDATION OF WATER SUPPLIES

Your Delegate was Chairman of the Reference Committee on Hygiene and Public Health to consider the fluoridation of water. The Council on Pharmacy and Chemistry had just previously declared that fluoride content in the communal water supplies to the concentration of one part per million was not toxic. Further than that the Council on Pharmacy and Chemistry did not go, although the general impression and the newspaper reports gave the wide credence to the report that the A.M.A. had approved the fluoridation of water. After much discussion and a good deal of testimony, the Committee decided to go on record as stating that the addition of fluorides to communal water supplies "seems to have merit" and endorsed "in principle" the fluoridation of communal water supplies where desired. Resolutions to put the A.M.A. on record stating that such measures were safe, economical and advantageous were disapproved.

The Committee on Hygiene and Public Health also considered and recommended the investigation of household products bearing no warning on the labels wherein certain poisons were dispensed such as carbontetrachloride, methylsalicylate and silver polish containing cyanide. All of these, though poisonous, are not labeled as such and many others are placed on the market each year which may be poisonous yet not be so labeled because they do not fall under the Federal Caustic Poisons Act. Our Committee recommended that the Board of Trustees conduct such a survey.

NATIONAL BLOOD PROGRAM

Also before the Committee on Hygiene and Public Health was the report of the Committee on Blood Banks. This report was adopted with minor changes. Essentially the Committee suggested that we should publicize the contraindications as well as the indications to the use of whole blood or blood fractions and not waste blood where it was not needed; to increase the awareness of physicians for the necessity of replacing blood taken from the bank; and to recommend that every donor be given a blood type card to carry with him at all times. The Committee also recommended a better cooperation among the organizations interested in the National Blood Program.

ACCEPTABLE MEDICAL SCHOOL

The "Essentials of An Acceptable Medical School" were submitted by the Council on Medical Education and Hospitals and was approved by the House, a copy of which is on file in the office of Rhode Island Medical Society if anyone is interested.

HOSPITAL ACCREDITATION

The Commission for Hospital Accreditation, containing the six representatives of the A.M.A., was appointed at this session. The first meeting will be held in Chicago on January 15th, with Dr. Stanley Truman of Oakland, California, and Dr.

Dwight Murray, of Napa, California, as GP members. It is noted that representatives of general practice as well as pediatrics are included in the A.M.A. representatives.

AMERICAN LEGION

Donald R. Wilson, the National Commander of the American Legion, made a stirring speech at the Los Angeles Session. He offered strong support in our battle to overcome socialized medicine. He spoke clearly and forcefully and minced no words about the support the Legion offered to Medicine in its fight against socialism. He stated very definitely the Legion intended, if possible, to prevent the merger of all Federal, medical and hospital activities including the Veterans Administration. No comment on the attitude of the A.M.A. toward this point was raised at this session.

Surgeon General H. L. Pugh, addressing the Scientific Assembly on Naval Medicine, also stated that he would resist the creation of a single Federal hospital system that is inclusive of the armed forces hospitals.

Summary

Taft and Byrd opposed socialism of Truman and also opposed socialized medicine.

Hess Report modified to make physicians alone accountable for infractions. Note that specialties of anesthesiology, pathology, physical medicine and radiology are an integral part of medical practice. If a hospital does not sell a physician's services, the financial arrangement between them may be on a mutually satisfactory basis. A physician should not dispose of his services to a hospital where they may be resold. Developments along this line will bear interesting observation in the months to come. Every District Society and the State Society should at once activate a Committee for Hospital and Professional Relations to be prepared to meet any situation developing between physician and hospitals to adjust the matter amicably and quickly.

The subject of medical care for dependents of veterans is receiving attention from the A.M.A. and apparently the voluntary health plans are recommended for their use rather than establishing another E.M.I.C.

The problem of the care of the veteran with non-service disability is the subject of a special committee for a future report.

The American Legion says it will support us in our fight against socialized medicine but wants no merger of hospitals and medical care under one department in the Government.

The A.M.A. says it has been scientifically demonstrated that Chiropractic is without merit in the healing art. There is no need for their graduates in the Armed Forces.

The Council on Medical Service is planning a Regional Conference to help correct the maldistribution of physicians.

The fluoridation of water supplies has received an "O.K. in Principle".

The national blood program received the attention of the A.M.A. and physicians are urged to become aware of their responsibilities in replacing blood taken from banks, to strive for better use of blood and not to waste it in conditions where it isn't indicated.

Whitaker and Baxter are retained on a part-time basis and funds for public education decreased.

All in all, a very interesting and busy session developed emphasizing the weighty problems engaging the attention of Medicine at the present time, problems which affect every physician practicing Medicine in the United States.

The next session will be held in Chicago in June and all those who possibly can, should make an attempt to attend and see for themselves the advances of scientific medicine, the wonderful technical exhibits, and to observe at close hand, the operations of the Sections and the House of Delegates in their deliberative assemblies.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

MEDICAL BREVITY

BREVITY IS the soul of wit—and it has many advantages at a medical meeting and in medical papers. Morris Fishbein used to say—and he was an undoubtedly brilliant and capable medical editor of wide experience—that physicians had to take a running start when they wrote papers.

There has been much improvement here. The style has changed and the writer gets right at his subject, but he does not get through it in the most direct manner. There are few papers sent in to the medical journals that could not be shortened to advantage.

It is rarely necessary to give the minute details of the physical examination. Don't say "examination negative" but when you are reporting on cancers of the large bowel you don't need to go into detail about the heart murmurs. You want your paper read, and most readers are pressed for time.

But your conscience does not need to bother you too much when you are verbose in print. The reader can throw it down and turn to something snappier. It is a different story when you have coaxed him into a medical meeting. He has cancelled his other dates and diffidence keeps him from stalking out of the meeting. But you are not making a hit with him if you are longwinded.

A clever little book recently told of a horticultural meeting in a sporting county of England. The gardener, about whom the book was written, was scheduled for some remarks. The chairman came to him and said, "John, be short if you can. Remember we are all getting a little saddle sore."

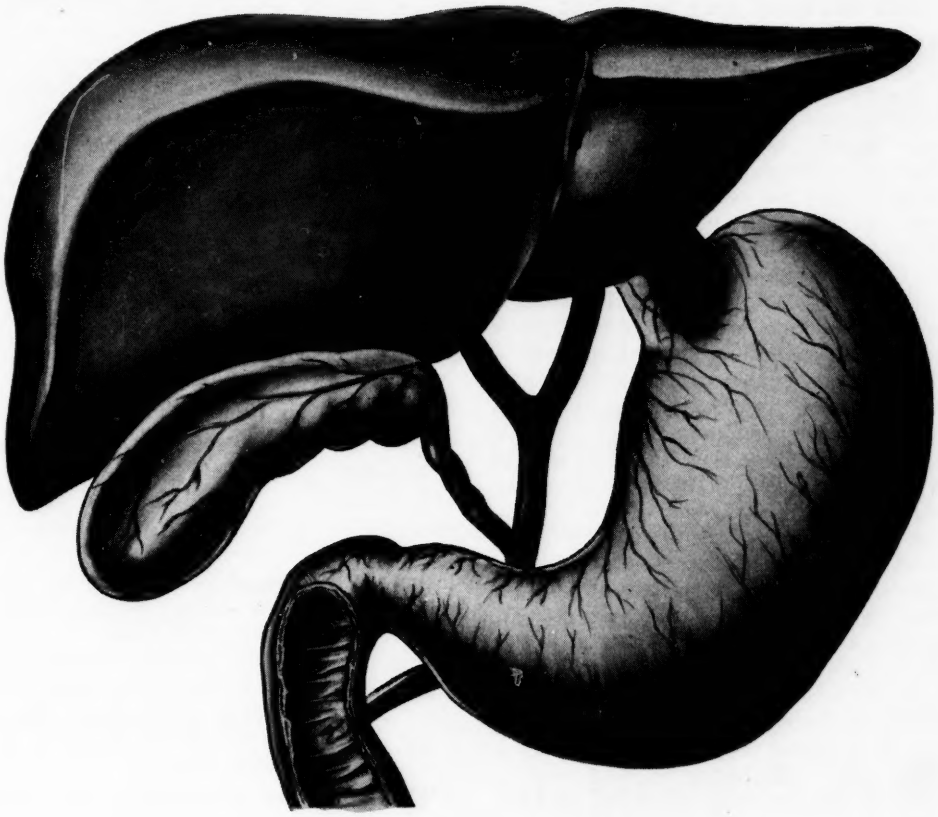
Local evening meetings should be particularly short and snappy. All the audience have done a day's work before they got there. When there is to be a social gathering at the end, ten thirty should see the scientific part ended. Yet a recent meeting went until well after eleven.

One paper took fifty-five minutes and the other fifty. Although each was basically of very high grade the elimination of much unnecessary detail would have been a distinct improvement.

An out-of-town speaker has just given a talk here scheduled for one hour. It was a masterpiece, and, as he is a clever man, he finished on schedule. Then followed an anticlimatic question period. At least two of the questions had been completely covered in the talk and others served only to reemphasize what could have been gathered from the talk.

At the outstanding big medical meetings all this is understood; the papers are scheduled for short periods and the brilliant men from the big clinics get through on time. They know they have to.

Dr. Gormly used to say that performers on the vaudeville stage had a saying, "Leave them while they are asking for more." That is the secret of stimulating meetings.



Possessing a definite hydrocholeretic action

KETOCHOL®

► Stimulates hepatic function thereby increasing the flow of bile

► Promotes biliary tract drainage, and

► Alleviates gallbladder stasis—

the *desired purposes* of gallbladder therapy.

KETOCHOL—*the 4 bile acids normally found in bile in oxidized (Keto) form.*

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

THE INTERIM AMA MEETING

The very complete summary of the interim meeting of the American Medical Association, as regards the action of the House of Delegates, is presented in this issue by Dr. Charles L. Farrell, our very able delegate from Pawtucket. We sincerely hope that every member will take time to read Doctor Farrell's report, and we remind the membership that *they* are the American Medical Association and therefore should have a knowledge of the actions of their elected leadership.

The action on the much-discussed Hess Reports warrant reading, and of equal interest is the action taken regarding medical care for dependents of armed forces personnel since this problem may ultimately evolve another EMIC of greater proportions than existed during World War II.

Of personal interest to every physician was the action taken to provide for a decision at the annual meeting next June in Chicago on a single membership classification. The board of trustees of the AMA has already voted to eliminate the $5 fellowship assessment starting this year, and now the question is whether all dues paying members shall be classed as members or Fellows.

Rhode Island was signally honored with the appointment of its delegate as chairman of the important Reference Committee of the House of Delegates on Hygiene and Public Health, marking the first time in many, many years that the representative from the smallest state has headed an AMA committee.

PROGRESSIVE HEALTH EDUCATION

The issuance by the health department of the City of Providence of its new Health Record booklet to the parents of each newborn child in the city, starting this month, is one of the best health education steps to be taken locally in many years. The idea for such a brochure stems from the pre-school examination committee of the Providence Medical Association, the child health relations committee of the Society, and Doctor Smith, city superintendent of health for the city.

Sized similar to a folded insurance policy the new booklet is ideally prepared for storing with valuable papers of any household, and it certainly promises to be one of the most valuable records that any family may maintain. The 16-page book provides listing for pertinent information relative to the child's birth, medical history for the first four years of life, a separate page for the pre-school examination, and additional pages for the recording of subsequent health checks during school years.

To the parent whose memory is sorely tried in recalling what illnesses, immunization tests, etc., her child has been subjected to during its early years, the booklet will provide an ever-ready reference. For the school physician, as well as the family physician, the record kept through the years will be invaluable in determining procedures and treatments for restoration or improvement of health.

In these days of forms, records, and sundried listings of human efforts it is truly inspiring that the type of booklet now being distributed by the Providence health department had not been evolved years ago. Belated, or not, the new Health Record booklet is certain to win wide comment, not alone from the parents of children born this year, but from health education authorities throughout the country.

TAFT AND BYRD ON SOCIALISM

Elsewhere in this issue appear the outstanding addresses by United States Senators Robert A. Taft and Harry F. Byrd delivered before the American Medical Association at its interim session at Los Angeles last month.

Both addresses should be must reading for every physician who is the least bit concerned with the inroads of socialism in this country. This may be a political year, but the addresses of these two distinguished members of the United States Senate, one a Republican and one a Democrat, strike us as frank appraisals of the threats to liberty as we know it in these United States.

As Senator Taft so eloquently said, "Liberty means your right and the right of every man to live your own life and think your own thoughts; to have those thoughts taught by others if you can find men who believe in them. Liberty is your right to spend the proceeds of your labor in such a way as you want to spend them with only a reasonable deduction for the necessary costs of government. It means the liberty of self-government; the right of every community to decide on its local institutions, how its children shall be educated, what local services shall be rendered and how, the form of local government, all without direction by some federal bureau in Washington; the right of states to run their own affairs. Liberty includes your right to choose your own occupation and run your own professional activities, or business, or farm, as you see fit to run it, except for such control as may be necessary to assure a similar freedom to others."

And from Senator Byrd who has on so many occasions pointed with clarity to the inherent dangers to human freedom in the expanding and excessive tax structure built by bureaucratic government, comes the warning that "we should always remember that human freedom is not a gift to man; it is an achievement by man, and, as it was gained by vigilance and struggle, so it may be lost by indifference and supineness."

THE BATTLE OF LIBERTY

UNITED STATES SENATOR ROBERT A. TAFT . . .

Addressing the American Medical Association and a National Radio Audience from Los Angeles, California, December 5, 1951

THE AMERICAN Medical Association is one of the leaders in the battle of liberty against socialism. I appreciate the opportunity they give me tonight to discuss that issue with the people of the United States. The fundamental problem before the American people today is how best to maintain the great progress they have made under liberty, and pursue their destiny to higher spiritual and material goals. That liberty is threatened by the forces of communism from abroad. It is threatened by the growing socialism and government control at home.

Liberty has been the key to our progress in the past, and it is the key to our progress in the future. I do not underestimate the value of democracy, a government by the people, but to me it is peculiarly valuable because it is more likely than any other form of government to assure liberty. But even under democracy liberty may be destroyed if the people become arbitrary rulers, or give arbitrary power to their representatives. Then liberty may disappear while the form of democracy remains. It is the great merit of the American form of Government that it undertakes to protect the liberty of minorities even against an autocratic majority of the people themselves.

What do I mean by liberty?

I don't like the term "free enterprise" because it seems to mean only the liberty of business, which is a small element. Liberty means your right and the right of every man to live your own life and think your own thoughts; to have those thoughts taught by others if you can find men who believe in them. Liberty is your right to spend the proceeds of your labor in such a way as you want to spend them with only a reasonable deduction for the necessary costs of government. It means the liberty of local self-government: the right of every community to decide on its local institutions, how its children shall be educated, what local services shall be rendered and how, the form of local government, all without direction by some federal bureau in Washington; the right of states to run their own affairs. Liberty includes your right to choose your own occupation and run your own professional activities or business or farm as you see fit to run it, except for such control as may be necessary to assure a similar freedom to others.

Results of Liberty

The results of liberty in the United States, where it has had a longer sway than in any other nation, has been a constant improvement in ideas and research and methods in every field of intellectual activity, in science, in welfare, and in knowledge. It has trained people to think for themselves and cultivate self-reliance. American armies have been the best armies in the world not because of better discipline, but because the American soldier has met each problem by thinking for himself. The American system, by offering incentive and reward and liberty, has steadily increased the productivity of the American workman and the American farmer, and, because the more goods are produced per person, the more there is to divide up per person, his standards of living, your standards of living. It is not so much that you or I are free and enjoy being free. It is that millions of Americans are free, and the competition of their ideas causes the best ideas to rise to the surface and finally prevail. Our business system is such that any man can have an idea, but also can have the idea tried out without getting the approval of some government clerk.

The man who has profited most from this liberty has been the man of low income. The wages paid in this country are more than twice those paid in Great Britain, and the average American worker has twice as much of all the things that make life worthwhile—of good homes and home equipment, automobiles, recreation and opportunities in every field of life.

This liberty is threatened today by what is roughly called socialism. By that I mean the grow-

continued on page 38

AGAINST SOCIALISM . . .

UNITED STATES SENATOR HARRY F. BYRD . . .

Addressing the American Medical Association and a National Radio Audience from Los Angeles, California, December 5, 1951

IT IS A PRIVILEGE to address the American Medical Association.

I am very happy to be in California and in this great city. I have a high respect and friendship for your two Senators, Knowland and Nixon. They are able, patriotic and influential. As a Democrat to two Republican colleagues, I am glad to pay this tribute.

I am told that the rules of this meeting prohibit a "partisan" approach. I submit that I can qualify as a non-partisan, and my record proves it.

Even I, a Democrat from Virginia, have been charged, in these days of stress, with voting with the Republicans. We have many statisticians in the Government at Washington. How they employ their time, I do not know, but they get out reports every now and then, and frequently on the Senators. They say that I voted 66 per cent with the Republicans and 34 per cent with the Democrats. My answer to that is this: My name begins with a "B" and as the roll is called alphabetically, I vote first, and the Republicans vote with me.

I can say with all sincerity that when these great legislative issues come before the Senate of the United States, the only test I apply is not whether these measures are of Democratic origin, or of Republican origin, but whether they are best for the United States of America.

I make no apologies for standing shoulder to shoulder with that great Republican leader, Senator Taft, when the effort was made to repeal the Taft-Hartley Act. I believe the repeal of that Act, demanded by President Truman in order to pay a debt he had assumed in his election in 1948, would have been the green light to labor leaders to do what they pleased in this country—stop our trains, stop our mines, stop the very necessities of our existence—unless we yielded to their demands. This act remains on the statute books because many of the Southern Democrats in the Senate and House voted to place country above Party. We Southerners are sometimes criticised, but every now and then we perform a useful purpose. I think we did in that instance.

What kind of a Democrat am I? I am a Jeffersonian Democrat of the old school who believes that simple honesty is still the very foundation of human character. I am an anti-socialist Democrat, which means, in plain language, I am *not* a Truman Democrat.

The essence of freedom, under our American democracy, lies in our system of checks and balances. Within the Federal Government, checks and balances are provided through a 3-branch system—the Executive, the Legislative and the Judicial. Beyond this, still other checks and balances are provided in our system of state and local governments, which lie closest to individual citizens from whom all governmental power and authority is derived. Our democracy has been given vitality by our system of competitive free enterprise, which, to this point, has made us, through individual initiative, the greatest nation on earth. I stand for this system, with the absolute minimum of governmental shackles. Our four foundation stones are freedom of religion, freedom of speech, freedom of the press and last but not least freedom of opportunity to the individual under the competitive enterprise system.

I Would Call It "Ruinism"

Many are warning us as to what may come unless we change our governmental course, which in the late years has been proceeding steadily towards state socialism. Some call the present trend collectivism, some call it statism, and some call it the welfare state, but let us not be technical as to the name of this new "ism". I would call it "ruinism" because these new policies of government, unless quickly checked, will destroy the American system.

America today stands at the crossroads.

We can continue down the road to state socialism and ultimate disaster, or we can strengthen and revitalize the free enterprise system and then go forward to a nobler and greater destiny.

continued on page 39

SENATOR TAFT

continued from page 36

ing power of government in the affairs of all of you individuals, and its increased activity in many fields where it has never heretofore been involved. Socialism is a matter of degree, because some fields of activity must be and some have been always conducted by government, notably the Post Office and public schools and public roads, but for many years the proportion of government activity was more or less static. In 1931, for instance, the federal government conducted 6 per cent of the country's activity, and collected 6 per cent of your income in taxation to do it with. The state and local governments took about the same amount, or a total of 12 per cent. In 1949, before this mobilization program started, the government was already spending ten times as much money as it spent in 1931, and had moved up to 18 per cent of all our activity plus 8 per cent more for state and local government, or more than 25 per cent of all the activity of our nation. The share of government had more than doubled. By 1953 the government will be spending 38 per cent of the total income. In Great Britain the government takes about 40 per cent.

The federal government has gone into many businesses for itself, and threatens to go into more. It has undertaken to regulate all industry and commerce and agriculture with great federal bureaus and huge subsidies. It has taken over functions which were almost exclusively local, and it threatens to take over all welfare services through a scheme known as social insurance which is not insurance, but simply more taxation to support free federal welfare services.

AMA Has Taken Lead

The American Medical Association has taken the lead in opposing this trend, and the doctors are justified in this because the key move of the socialists today is the effort to set up a federal system of socialized medicine. The government proposes to collect six or seven billion dollars, mostly in payroll taxes from workmen, and set up a vast federal bureau to employ nearly all the doctors in the country to furnish free medical service to all the people, including the great majority who are perfectly able to pay for it themselves. The program, of course, would supersede all our private, state and local activity in furnishing medical care. It would destroy the independence of the American medical profession which is responsible for more improvements in health care and remedies for disease than any profession in the history of the world. It would bring the federal government's agents into every home more than any other service could possibly do. If the service is like most federal services, or like that of Great Britain, it would be pretty poor service.

But medicine is only the opening wedge. In Great Britain the government furnishes free service for the birth of babies, for the support of children, for burial at death, and for every misfortune of life. That is the goal of our Federal Security Administration as set forth in several of its annual reports. More government regulation also faces us in peacetime price control and wage control and rent control and agricultural control, until, as in England, the government will tell every man how he must run his business, when he can expand or not expand, what machinery he can buy, and what wages he can pay. In agriculture the proposals would soon lead, as it has in England, to the government telling every farmer what he can raise and what he can't raise, how many beef cattle he can feed, how many dairy cattle he can keep, how many hogs and chickens he can raise.

What is the purpose of this vast expansion of government activity? Supposedly it is for the welfare of the man of low and middle income, but they have it all in England and the British workman gets wages equal to about 40 per cent of what the American workman gets, and has less than half the standard of living. He is just as good a workman. His trouble is that there has not been in England, either in business or in government, or in labor, the freedom which has existed here.

Socialism Destroys Incentives

Socialism draws a beautiful blueprint, but it utterly destroys the incentive of the individual manufacturer or the individual workman. In its effort for equality, it reduces everyone to the dead level of mediocrity. New ideas are discouraged. It moves towards its goal of complete equality, but the lower income American workman is better off than the average man in a socialist country. If we took everybody's income over ten thousand dollars a year and distributed the excess to the other workers, there would be less than 2 per cent improvement in their wages; and that wouldn't last because no one would go on working to earn over $10,000 a year if taxation was going to take it all. But a free system has resulted in a steady increase of productivity at the rate of 3 to 4 per cent every year, reflected in constantly increasing wages and standards of living. It is the low and middle income workers who profit most from liberty.

If socialism takes 40 per cent of the income of the country, in the long run it takes from 25 to 40 per cent of your income. Socialism is expensive. It causes tremendous taxation. A lot of those taxes are passed on into the cost of goods which you buy. Even the man of lowest income today already pays 20 per cent of his income in taxes, either directly or in the increased price of every article that he buys.

You are thus deprived of the liberty of spending

continued on page 40

SENATOR BYRD

continued from page 37

There are those who believe that socialism can be turned on and off as if it were water flowing through a spigot, and there are those who profess to believe we can have a little socialism and remain free.

For those who think "a little socialism" is a good thing, there is the British example. From what we see in England, we would be the most stupid nation on earth if we allowed ourselves to become further embraced by the socialism which has been creeping upon us. Socialism and free enterprise cannot live under the same roof. England thought they could, but, to her sorrow, she has found it is impossible. She socialized the coal mines, and the production of coal immediately declined. For the first time in her history, England is now importing coal. She socialized the steel industry, and the production of steel immediately declined. She socialized civilian aviation, the electric supply industry, the Bank of England, the inland transportation system, the gas industry, and many other functions and enterprises essential to the welfare of her people, including socialized medicine, agriculture and the legal profession.

A friend recently sent me a copy of the *London Times*. On the first page it had a list of 150 farmers whom the Government had charged were guilty of bad husbandry, because they had not obeyed the Government Bureau on what to plant, when to plant, and when to harvest. This notice said that unless these farmers mended their ways their farms would be confiscated. Not paid for, not condemned, under the law, but confiscated, and this in the land of England! For a thousand years England has boasted that the Englishman's home is his castle, and now under Socialism our friends across the sea have reached such a low estate that if a farmer does not obey the order of a bureaucrat, he is subject to the penalty of having his property taken from him.

In England there are only 70 Britons who have a take home income of $16,800 or more, after taxes. The rich have been liquidated. But to liquidate the middle classes you strike at the heart and core of any country. This England has been gradually doing, as there are only 320,000 Englishmen now who have incomes of from $2,800 to $5,600 or more a year, after taxes.

In the face of these facts, are we going the road of England?

Just recently, England, with momentous effort, decided to attempt the road back. By direct vote, she ousted the Socialist Labor Party and installed Winston Churchill, who I think is the greatest man in the world of his generation, and to whom England has so often turned in her days of peril. But I fear there is little reason to expect that even under this great leadership England can return to the free enterprise system. England has repented and all of us wish her well, as she is our friend and ally.

As I see it, the welfare state, about which we have been hearing so much in recent years, is that state of twilight in which the glow of democratic freedoms is fading beyond the horizon, leaving us to be swallowed in the blackness of Socialism, or worse.

Mirage of Easy Money

In many federal programs we are chasing a mirage of easy money in the form of deficit dollars. Some of us have been duped into believing that the easy dollars handed out by the Federal Government are something for nothing, but, actually, these programs are adding to the public debt, are undermining the will of individuals, regimenting the production of agriculture and labor, controlling the practices of business, curtailing the solvency of states, and destroying the self-determination privileges which are traditional in our local governments and domestic customs.

Make no mistake: It is Socialism which lies at the end of this rainbow, and, in this rainbow, the predominating color is the red of federal deficit spending under which a whole new generation of Americans has grown and developed.

As to where we stand today, the last time the Socialist Party in the United States campaigned actively in a Presidential election was in 1932. Today, virtually every plank in that 1932 Socialistic platform has been enacted into federal law, and in some cases, enlarged upon. For this reason I assume the Socialist Party as such has not been active since they have gained their objectives. Read this platform and you will see.

This is not a brash opinion of my own. Let me call to the witness stand Earl Browder, former leader of the Communist Party and an authority on Communism and Socialism, who recently listed 22 socializing items adopted by the Federal Government ranging through deficit financing, price controls, Government housing, and "full employment" laws. These 22 items, he said, expressed, I quote "The growth of State Capitalism . . . an essential feature of the confirmation of the Marxist Theory . . . It represents the maturing of the objective prerequisites for Socialism, the basic factor which makes Socialism inevitable." Unquote.

Mr. Browder further said: I quote, "Socialism has progressed farther in America than in Great Britain under the Labor Government, despite its nationalization of certain industries, which is a formal state not yet reached in America." Unquote.

Adoption of the Truman Fair Deal program, as he has outlined it . . . and recently reaffirmed it

continued on page 41

SENATOR TAFT

continued from page 38

the money that you have earned. The government spends it for you. If the present increase goes on, the time will come when the government takes 75 per cent of your income. Then you will be like the little boy in boarding school with some spending money in your pocket, but the government, like the school master, will tell you when to get up, what to eat, what to do and when to go to bed. It is just as easy to get complete socialism by more spending as it is by government directly taking over one business after another.

This whole danger has come upon us gradually. Each project is presented as something to improve somebody's condition without consideration of its effect on his freedom and that of others. The more powerful the government becomes, the stronger its propaganda in behalf of more power. The trend cannot be stopped, unless you are willing to elect both a President and a Congress who believe that the maintenance of liberty is the first and most essential consideration for progress.

But those who dwell on the importance of liberty must recognize the proper functions of government, and their case is weakened unless they recognize that there are necessary limitations even on liberty. What we seek is liberty for all the people, not for any special group. In a great complicated industrial community, liberty cannot become laissez faire. There cannot be a negative government action in its proper field or even some increase to meet new problems.

Functions of Government

First. Government action may be necessary to maintain a limited liberty for all in our complicated modern life. We have more red and green lights at our corners to prevent confusion in traffic and other regulations so no one can hog the road. We have a Federal Communications Commission to prevent utter confusion on the air waves in radio and television. We have a Civil Aeronautics control because we desire safety in the air. But in all of these necessary regulations, the important thing is that they be undertaken so as to preserve the utmost liberty possible in highway and air traffic, radio, television and the like.

Second. We have found that some government regulation is necessary if we are going to retain liberty itself in business. Thus, we found that without any government regulation, we were likely to have monopoly in many fields of business. Without the Sherman Act there would have been no freedom to go into, or stay in, business. Probably our industrial progress is due as much to protecting commercial freedom as any other factor. We see the vivid contrast in the stagnation of industry produced by the cartel system abroad. Thus, also, a free market is only possible if some protection is given against economic oppression and manipulation. We have enforced collective bargaining so that the fixing of wages may be on a truly free basis, as against the condition where an employer dealing with thousands of employees individually had an undue advantage in fixing wages. We also protect cooperatives in the farm field so that the individual farmer may not lose his economic freedom to obtain a fair price for his crops, because he is such a small unit dealing with a large buyer or a market dominated by buyers. But in all of this legislation the important thing is to realize that the purpose is to protect liberty and a free price and wage determination for the greatest possible number of people, and not to carry out some ideal economic control and direction of wages and prices and production conceived by a socialist planner.

Third. Government certainly has the obligation in this country to relieve hardship and distress where private charity cannot do it. The advantage of our system is that it assures, roughly, a return in money measured by the work done and services performed, and thereby gives the incentive to do more and better work and more and better thinking. But under that system many must fall behind because of misfortune or their own lack of ability. Socialism claims that its advantage is in treating all equally. That is an ideal it has never attained, but it has destroyed incentive to improve. But the American people are charitable people and they feel that this country is so productive that perhaps for the first time in history they can abolish hardship and distress from economic causes. Also our Constitution has as one of its ideals equality of opportunity, and the American people have come to feel that every child should have something like equality of opportunity no matter how poor the family or the community into which he may be born. Our state and local governments have always offered free primary and secondary school education in this country. They have undertaken to provide relief and old age assistance. They have given free medical care to those unable to pay for it. Practically every city has a general hospital for that purpose and, while there may be gaps in service that could be closed, we do have throughout our country as good medical care available for the unfortunate as any country in the world. Our local governments, with federal aid, have undertaken to provide free housing for those unable to pay enough rent for decent private houses.

I quite agree that when you get in this field on an extensive basis you have to be careful not to go on to socialistic service for all. In fact in free schools and in the old age and survivors insurance system we have taken two steps into socialism; but I do

continued on page 42

SENATOR BYRD

continued from page 39

. . . would irrevocably put us on a one-way street to State Socialism.

Mr. Truman says it is an insult to the intelligence of the American people to say this country is on the road to Socialism. I submit that it is an insult to our intelligence to assume that we do not realize that adoption of the President's program will commit us irrevocably to a Socialistic state, from which there can be no retreat.

Questions for the President

If the President is against Socialism, I ask him to answer these questions:

Why does he continue to pressurize Congress to adopt socialized medicine? He sent Oscar Ewing, at public expense, to England to get the "low-down" on their socialistic system for propaganda use in the United States. If the President does not recognize that the British experiment in medicine is socialism, he could inform himself from the debates in England during the last election. The President calls his plan national health insurance, but it is socialized medicine just the same.

The cost of socialized medicine in America is difficult to estimate. We do things on a very grandiose scale when it comes to spending money, as you know. If the Federal Government undertakes to pay the expenses of our children when they are born, guard them through their lives from illness and the things that may happen to them, and then bury them, the cost will be huge. Some of the statisticians have estimated the ultimate cost at twenty billion dollars annually, and in fifty years, that amounts to one trillion dollars.

These statisticians further said that if you take one trillion dollars piled on top of another, it would extend two million ninety-six thousand miles high — seven times the distance to the Moon — with enough left over to pay our present national debt. I am told that is accurate, but I have not checked it.

If the President is against socialism, why is he advocating the Brannan Plan, which inevitably means socialized agriculture? This plan not only would contribute in a huge way to the bankruptcy of America, but would create such chaos in the production, sale and distribution of food as to make it necessary for the Government to take over these functions that must remain competitive in private hands. President Truman and Secretary Brannan are now conducting a nationwide campaign to force the Brannan Plan through Congress, notwithstanding the fact that the great farm organizations such as the American Farm Bureau Federation and the National Grange, as well as most of the farmers of this country, are bitterly opposed to this plan. They realize it will be the end of free enterprise in agriculture.

The only sincere thing Mr. Brannan has said about the plan is that he could not estimate the cost of it. Testifying before a committee of Congress, he gave this glowing picture of what the Brannan Plan would do—reduce the cost of food to the consumer, pay the farmers a high profit for what they produce—but he did not fill in the gap by telling how the Federal Government could obtain the vast sums necessary to pay for the difference between food at low cost to the consumer and high prices to the farmer.

If President Truman is opposed to socialism, why is he advocating another extension of socialized housing?

These three proposals alone would mean socialization of your health, your food, and the roof over your head. If time permitted many other trends to socialism could be cited. If the President is opposed to socialism, why is he constantly advocating an extension of the number of those who receive payments from the Treasury of the United States? Today, there are 17 million Americans receiving regular payments directly from the Federal Government, and eight million more are on the rolls of counties, cities and states. These twenty-five million, with their families, constitute a substantial part of our population.

Socialism can be effectively promoted by constantly increasing those who are on the public payroll. A population of government dependents is a socialized population.

Among the cardinal characteristics of socialism are government subsidies with controls, and government doles with regimentation. I am against that.

No Substitute for American System

The American system, operating in the fullest freedom of democracy, stimulates individual initiative to the development and production of more of what we need, in peace or war, at a cost we can more easily afford from the earnings of our endeavor. I am for that.

The American Medical Association needs no definition of the free enterprise system from me. It is the system which, in the relatively short span of one hundred sixty years, has brought us from the impotency of thirteen un-united colonies to our present position of world leadership. I do not concede that it should be scrapped for socialism in welfare state clothing which never brought greatness, happiness or security to any nation.

The American system has developed individual freedoms under constitutional democracy to the fullest measure ever known to man. It is the system which is always ready to supply the vital spark needed by the deserving to expand mediocrity into genius. It is the system which supplies the incen-

continued on page 43

SENATOR TAFT

concluded from page 40

not think that term can be applied to the charitable effort to remove extreme hardship and distress.

State and Local Control Vital

If we don't want charity to develop into socialism, however, there are certain definite rules to be followed. First, there must be state and local control, and the service must under no circumstance be federalized. I do not think you can maintain freedom in a country of our size in any field ruled by federal bureaus. They are too far from the people. They are so far from the people that they can't determine who is in need and who isn't, as we saw in W.P.A. days, and their policy becomes one of handouts for all. They are in no way responsive to public opinion. They make no allowances for the local differences of physical condition or custom or taste. The federal government may reasonably furnish advice and research. In clear cases of need, it may furnish assistance, but it should never control or regulate. For this reason, if there is any federal aid, it must be dispensed on definite statutory rules, with minimum discretion in federal officials. We have found that if such discretion is given, it leads to an effort to withhold money until the state or locality complies with the ideas of some Washington bureaucrat as to how the service must be conducted.

State and local government services, seeking federal aid, must not only be confined to those in real need, but the standard of need must be a minimum one which does not make the recipient of government money better off than the man who works for a living. After all, to the extent that government supports those who are not working or not carrying their share of the burden, it can only do so by imposing more taxes on all the people who are working. It is an illusion to think that you can get this money out of corporations or the rich. If you confiscated all income over ten thousand dollars a year per person, you would get three billion dollars more than today. Socialized medicine alone will cost from six to ten billion, minimum. The way costs are going today it might even reach 18 or 20 billion. We cannot impose on the hardworking people of this country a burden so great to support the nonworkers that it reduces their incentive and their standards of living.

With the tremendous military spending we now face, I doubt if we should undertake any additional program no matter how meritorious. My own feeling is that we endanger the whole economy of this country if we permit the total tax burden to run over 25 per cent of the income of all the people. Where it has reached 40 per cent, there is no longer any incentive for private development, and little doubt that socialism will continue to spiral upwards.

But whatever government project may be justified, it is vital that those who enact it, and those who administer it, have constantly before their eyes the maintenance of the greatest possible liberty for the greatest number of people. The justification for any government action must be clear and beyond question. The New Deal and Fair Deal rulers of this country have been deterred by no such considerations. They have been inspired by the philosophy that only the government can solve the problems of the people. Only the government has the ability to design beautiful economic plans. Only the government or they themselves who run the government have the expert knowledge to know what is good for the people. If any problem arises, they have only one solution—create a new government board and give it all the power and money it asks for to find the solution. From their standpoint there is no limit to the spending by government. The taxpayer is inexhaustible. In fact they favor spending for spending's sake and for the inflation they hope to produce. They are determined to centralize all power in Washington. They have a basic contempt for the people's views and the views of local communities. They are the experts, and they propose to impose their false Utopias on the people whether they like them or not. They ask for power unlimited by law, and if limitations are imposed they do not hesitate to evade them and treat Congress with contempt—at least until a major investigation is undertaken. There can be no doubt that if the present trend continues, there is no end until the Nation sinks under the weight of a crushing bureauracy with the tremendous taxation and limitation of freedom which it requires.

If we can preserve liberty in all its essentials, there is no limit to the future of the American people. There are no frontiers to human improvement. The progress that America has made can be an example for the entire world to follow, while we go on still further to open new opportunities for all mankind. But we cannot do it under the leadership of today, or under the creeping philosophy of socialism which has even affected your thinking and mine more than it should. I am always inspired when I consider again the wisdom of the founders of this Nation, and astonished to see their clear analysis of the necessary principles of freedom, and of justice and equality incident to such freedom. May our leaders be inspired by those ideals, and seek progress by applying them to the new conditions of a world which physically has changed, but a world where the principles of human liberty are eternal.

SENATOR BYRD

continued from page 41

tive to every American to start at the bottom and rise to the top.

It is the system which enables us with only six per cent of the world's population to out-produce the rest of the world combined. It is the system which produces steel, the prime requirement for military defense, at a rate of more than two tons for every one produced by the rest of the world—at a rate of more than four tons to every one ton produced by Russia.

I challenge the socialists to offer a practical substitute for the American system's capacity to hold Russian world aggression at bay.

Our free enterprise system is a greater deterrent to Russian aggression than the United Nations ever will be. It is this system which is our first line of defense. Our armies, navies, and air forces are merely the tools through which the strength of this system is applied in war.

With our eyes wide open, will we yield to the ever-increasing socialization of those freedoms and institutions which are vital to our democratic free enterprise.

With respect to the checks and balances against federal zealots provided in our system of state and local governments, there is pending in Congress now legislation, with Presidential approval, under which the Federal Government would usurp local police power and state control of elections.

With respect to checks and balances between the executive branch and the Congress, the Honorable Roswell P. Magill, former Under Secretary of the Treasury, now president of the Tax Foundation, recently testified that despite the constitutional mandate that federal expenditures be controlled by Congress, I quote "Congress does not have that kind of control today." Unquote. It has been chipped away insiduously over the past twenty years by give-away program after give-away program which have committed the Federal Treasury without annual review by Congress.

The Taxation Issue

From George Washington's administration to April, 1945, including the Roosevelt Administration, the Federal Government took in taxes from the American people two hundred forty-eight billion dollars. In six years and two months, from May 1945—when Mr. Truman took office—to June 1951, the Federal Government took from us two hundred fifty-five billion dollars.

In plain words, in less than six and one-half years, including only three months of World War II, Mr. Truman has taken from the people in the form of Federal taxes seven billion dollars more than was paid into the Federal Treasury in the previous one hundred and fifty-six years of our existence as a nation.

This is the record of Mr. Truman, the tax collector. Now let us look at the record of Mr. Truman, the spendthrift. From the administration of George Washington to the beginning of World War II, Federal expenditures totaled $179 billion. From the end of World War II, in six years under Mr. Truman, the Federal expenditures totaled $260 billion, or $81 billion more than in the entire life of our nation, excepting the three and a half year period of World War II. When I first compiled these figures they appeared to me to be so incredible that I have them checked from official treasury records. The figures are correct.

In fiscal 1953 the Budget Bureau estimates the Federal expenditures at 85 to 90 billions. If so, Mr. Truman will spend in one year—the year beginning July 1, 1952,—more than one-half as much as all previous presidents spent up to World War II.

It is alarming to note that in only one year in our history have we exceeded this estimated 1953 fiscal year spending. In fiscal 1945 at peak of World War II we spent 98 billion. Then we were financing the greatest war in history. Now we are engaged in a police action in Korea.

How much farther can we go in this reckless financial irresponsibility?

Now for a "Byrd's"-eye view of the Federal budget:

Based upon the Budget Bureau estimate of spending for fiscal 1953 the deficit will be from 17 to 20 billions in one year as the income from Federal taxation in this year under present tax rates will be sixty-eight billion dollars to seventy billion dollars.

In addition, our local and state taxation will be about nineteen billion dollars.

Americans are paying nearly 30 per cent of the national income in taxes. Our taxes have reached the confiscatory stage, which means that new taxes will probably result in diminishing returns.

In the circumstances, it is natural to ponder the question: When does a democracy become insolvent? In a system such as ours, when and how does national insolvency manifest itself? There probably will be no milestone to mark the crossroad, but it seems to me that a democracy is approaching insolvency when:

(1) We are unable to pay current costs of Government over a prolonged period with taxes short of confiscation and diminishing returns and,

(2) When the constant cheapening of the dollar is a result of these government operations.

If these are the symptoms, it would appear that the diagnosis of our present and prospective fiscal situation is unmistakably clear.

continued on next page

The thing that is most inflated in America today is the Federal Government. Big government costs big money. Inflation is conceived and born in Washington. Only the Federal Government can spend in unlimited amounts. It alone determines the value of money and the extent of credit, because it alone is legally empowered to do so. A federal bond is a first mortgage on all the property owned by every American citizen.

The reckless spending of the Truman administration has precipitated a Federal fiscal crisis which many of us may not fully realize, but, unless we retrench we can anticipate a constant deterioration of our currency and credit. There is only one road to solvency, and that is to stop spending money we do not have by elimination of every single nonessential disbursement. Yet, every effort by Congress to retrench is vigorously opposed by the President and his cohorts. There is, in my opinion, only one untouchable item in the budget of the Federal Government, and that is the interest on the public debt. This we must pay as a matter of honor and to preserve the value of our bonds.

The one overshadowing characteristic of the administration now in Washington is fiscal weakness and irresponsibility. From this springs the demand for confiscatory taxes, stifling controls and centralization. If American democracy is destroyed, it will be the result of fiscal irresponsibility of which the present administration is guilty, and which even now, is being exploited by political camp followers who would centralize all power and purse control in Washington. From these come a deadly assault on the free enterprise system, the creeping socialism and the scandals which Thomas Jefferson foresaw when he said:

Quote: I do verily believe that a consolidated government would become the most corrupt government on earth. Unquote.

Forces of Freedom Need New Recruits

As I witness the moral deterioration of our government at Washington which has shocked and stunned the American people, once again I pay tribute to the foresight and wisdom of Thomas Jefferson, the founder of the legitimate Democratic Party.

I do not concede that either democracy or free enterprise, or any other American freedom has run the course of its usefulness in the world. They have been worth fighting for in the past against both economic and military challenge, and I do not concede that they were any dearer to those who have fought and won before than they are to us today. The battle lines are drawn. I am ready to fight. I hope you are. The forces of freedom in America need recruits.

What can we do? What can you do? I am frequently asked that question. I would say, first, that

you must stand firmly against socialistic trends, because a little socialism inevitably means more and more socialism. There are many doors to the house of socialism. It is very easy to get in but very hard to get out. Let us not be lead into socialism by the back door. Let us judge for ourselves where these new "isms" will lead us and not be deluded by those who pay lip service to free enterprise and then advocate those things that would destroy it.

The American Medical Society has waged a clean — aboveboard — effective campaign against socialized medicine. You are fighting to preserve the great principles of our Republic. You realize, as all of us should that socializing an important segment of our daily life, means that sooner or later further socialism will encompass other activities, resulting in a complete socialistic regime.

Do not be deluded into a sense of false security. Those who insist upon committing this country to socialism are ever on the alert. Today in the Senate of the United States there are few votes for socialized medicine. But when the slightest opportunity opens you will find those promoting these measures, ready to strike, like a snake in the dark.

If Mr. Truman is re-elected on this platform of state socialism he will assert that he has a mandate from the people to enact this full program into law.

Then I would say that you, the people of America, the voters at the polls, must demand that short of total war our Federal Budget must be balanced. I do not ask for "pet" federal appropriations but demand that the President and the Congress keep the federal spending within the ability of the people to pay. Let us all recognize that we cannot pyramid deficit after deficit on an existing federal debt of $260 billion and survive as a democracy.

Once the American dollar goes down, we will enter an age of international darkness. The American dollar is the only thing today that is holding the world together. It is the only currency that everybody, everywhere in the world, has confidence in.

Those who, willfully or otherwise, would destroy the American system would destroy the freedoms of people everywhere. Today, we alone are bearing the standard.

What nation can carry it if we fail? Without its light, freedom and progress would perish from the earth. We must not fail.

Without American solvency there would be no deterrent to communism abroad. In the existing circumstances it is no exaggeration to say that there is literally nothing on earth more important than the preservation of the fiscal integrity of the Federal Government of the United States and of the economic freedom of the enterprise system.

In conclusion, let me say, we should always remember that human freedom is not a gift to man: it is an achievement by man, and, as it was gained by vigilance and struggle, so it may be lost by indifference and supineness.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The September meeting of the Newport County Medical Society was called to order at 9:00 p.m. by the President, Dr. Henry Brownell.

The minutes of the previous meeting were read and approved.

Communications were read. In reference to Dr. Eske Windsberg's communication, Dr. Adelson made a motion that To adopt the fee schedule that the House of Delegates adopted May 3, 1950 as it applies to "wards and dependents of government" and that To adopt such future amendments that the House of Delegates may adopt on this matter. The motion was seconded and passed.

The Councillors had nothing to report.

The Delegate stated that there had not been a meeting of the House of Delegates since May.

Dr. Brownell asked the censors for a report at the next meeting on Dr. Bronie Apshaga of Block Island.

Under new business, Dr. Zamil (speaking for Dr. Burns) brought up the Diabetic Detection Drive to be held November 11-17, and asked the doctors to report on all urines that they examine during that period.

Dr. Adelson felt that the action of the Society at the previous meeting on the fluorinization of water may have been hasty and questioned the advisability of forcing fluorine on the entire population through water supplies. Dr. MacLeod was asked to elaborate on this at our next meeting.

Dr. Zamil moved that the treasurer be authorized to purchase more Society car insignia. This was seconded and passed.

Mr. Ward Harvey spoke on the "Doctor in Court."

Meeting adjourned at 9:45 p.m.

Attendance 16.

Respectfully submitted,

M. O. GRIMES, M.D., *Secretary*

BRISTOL COUNTY MEDICAL SOCIETY

The Bristol County Medical Society held its annual Fall dinner meeting and election of officers at the Midway in Bristol, Rhode Island, on October 16, 1951.

The meeting was called to order by the President, Dr. Samuel Clark, who announced that the slate of officers for the coming year as presented by the nominating committee had been unanimously elected to office.

The gavel was then handed over to Dr. Charles E. Millard of Warren, the incoming president for 1951-1952, who announced the additional slate of officers as follows:

Vice President: Dr. E. Paul Bruno
Secretary: Dr. Charles W. Dunbar
Treasurer: Dr. Robert E. Drew

It was noted that Dr. Drew has been elected Treasurer of the Society for the second consecutive year.

Attendance was 15.

Respectfully submitted,

CHARLES W. DUNBAR, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held on October 23 at the Kent County Memorial Hospital in Warwick.

The meeting, a joint Medical-Dental meeting, was called to order at 9:10 p.m. by the President, Dr. Jean M. Maynard, who first extended welcome to the members of the Dental Society. The minutes of the September meeting were approved.

Dr. Abbate reported for the censors, approving the applications of Drs. Charles B. Round and Peter E. Canale for active membership. Application of Dr. Richard Kraemer for associate membership was tabled until the formality of permission from his county society is granted.

It was regularly moved and voted that Drs. Round and Canale be elected active members of the Kent County Medical Society and that Dr. Kraemer's application be tabled until the necessary formalities be attended to as outlined in Chapter I, Section IV of the By-Laws.

Dr. Hardy reported briefly on the work of the Disaster Committee. He stated that plans were not yet definite but that probably almost all the doctors of Kent County would be involved in the November 4 demonstration.

An application for active membership from Dr. Richard Dyer was received and turned over to the Board of Censors.

Dr. Abbate moved that Dr. Harold Collom be appointed a committee of one to establish rapport

continued on page 48

A MEASURABLE ADVANCE

in the relief of

symptoms

of the common cold

CORICIDIN

In a study of 5,734 patients with the common cold treated with CORICIDIN,® "...the relief of symptoms was 72.7 per cent...."* Side effects were mild and their incidence only 1.5 per cent greater than with the placebo.

CORICIDIN contains the most potent antihistamine available — Chlor-*Trimeton*® Maleate as well as aspirin, phenacetin, and caffeine.

CORICIDIN (antihistamine, antipyretic, analgesic) Tablets are available in tubes of 12, and bottles of 100 and 1000 tablets.

*Manson, M. H.; Wells, R. L.; Whitney, L. H., and Babcock, C., Jr.: Internat. Arch. Allergy & Applied Immunol. *1*:265, 1951.

Schering CORPORATION • BLOOMFIELD, NEW JERSEY

CORICIDIN

KENT COUNTY MEDICAL SOCIETY

continued from page 46

with the proper hospital authorities to procure collation after monthly Society meetings.

This motion was seconded and adopted.

Dr. Nicholas Migliaccio then presented an interesting description of fractures of the jaw and control of bleeding. His talk was illustrated by the mechanical devices used for immobilization and by X-rays of actual cases.

Attendance was 16.

Meeting adjourned at 10:50 p.m.

Respectfully submitted,

JEANNETTE E. VIDAL, M.D., *Secretary*

The regular monthly meeting of the Kent County Medical Society was held on Tuesday, November 20, 1951 at the Kent County Memorial Hospital with the President, Dr. Jean M. Maynard in the chair.

Minutes of the October meeting were voted approved.

Dr. Richard Dyer was voted in as an active member of the Kent County Medical Society after routine approval of his application by the Board of Censors. Application of Dr. Edmund Brasset was received.

The President then reported on a meeting of the Committee on Public Relations of the Rhode Island Medical Society which was held in Providence on November 8.

The several subjects touched upon were as follows:

For County Society information:

1. Physicians Service has set aside 5% of its annual income as a reserve fund required by the State Insurance Commissioner. The fees cannot be adjusted to absorb the surplus created by this fund without permsision of said Commissioner.
2. Form letters will be sent out to Physicians Service subscribers after hospital discharged signed by Dr. O'Connell requesting comment on the plan.
3. The Cash Sickness Program requests more cooperation from doctors in mailing in forms as soon as they are received.

For County Society action:

1. For the appointment of a grievance committee.

   It was moved, seconded and voted that the Public Relations Committee of the Kent County Medical Society which is composed of its President, Vice President and Secretary, serve as its Grievance Committee, and that the names of this Committee be sent in to the Rhode Island Medical Society.

2. For an emergency call list.

No action was felt necessary by the Society as a whole for such a plan is already in existence and satisfactory in West Warwick and Coventry.

3. For a response to the Orientation course for new Medical Society members.

It was felt that such a course would be very helpful and that no definite action was necessary other than mailing lists of new members to the State Medical Society.

It was moved, seconded and voted that a letter be sent as requested, in triplicate, to the American Red Cross, Warwick Chapter, approving the Red Cross Program in principle for the collection of Blood for Defense.

It was also approved that the Kent County Medical Society have representation on three committees of the Rhode Island Medical Society, as requested by Dr. Herman A. Lawson.

The following members were appointed to serve:

1. On Air Pollution—Drs. Edmund Hackman, John Mack, Paul Barber.

2. On the Advisory Committee on the Cash Sickness Compensation Program—Dr. Peter Koch.

3. On the Civil Defense and Disaster Committee—Dr. Arthur Hardy.

The President then appointed two committees for the December meeting. Drs. Fenwick Taggart, John Mack and Royal Hudson were appointed to the Planning Committee, and Drs. Peter Erinakes, George Young and Russell Hager to the Nominating Committee.

Dr. Joseph Wittig then delivered an interesting instruction talk on "The Neurological Examination."

Attendance was 21.

Meeting adjourned at 11:10 p.m.

Respectfully submitted,

JEANNETTE E. VIDAL, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular monthly meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, December 3, 1951. The meeting was called to order by the President, Dr. Louis I. Kramer at 8:30 p.m.

With the consent of those in attendance the Secretary was excused from the reading of the minutes of the previous meeting since they were published in the *Rhode Island Medical Journal.*

The Secretary reported that at a recent meeting the Executive Committee, in accordance with the by-laws of the Association, had prepared and submitted to the membership a proposed slate of officers to be voted on at the annual meeting on Monday, January 7, 1952.

continued on next page

Dr. Kramer announced the appointment of an obituary committee to prepare the Association's tribute to the late Dr. Angelo Scorpio of Drs. Daniel Troppoli and William P. Dugo.

The President announced that Dr. Frank Lahey of Boston would address the Association at its annual meeting on January 7, 1952.

The first speaker was Dr. Herbert Fanger, Director Pathologist of the Institute of Pathology, within the R. I. Hospital, who spoke on "Experiences with 'Papanicolaou' Smear Diagnosis for Cancer."

Dr. Fanger described in detail the technique of the Papanicolaou Smear as it is carried out at the Rhode Island Hospital. At the Rhode Island Hospital the material for the smear is taken from the posterior vagina. In other Clinics, smears are taken also from the cervix.

3,338 smears have been examined since 1948. 1,047 smears have been examined in 1951 thus far. This number includes smears of bronchial secretions and of the sputum. Of the total number of smears examined thus far 345 were vaginal smears checked by biopsy examination. 13 smears were found to be positive, confirmed by biopsy.

Dr. Fanger showed beautiful Kodochrome slides of representative Papinicolaou Smears.

The second speaker on the scientific program was Dr. Howard Ulfelder, Clinical Associate in Surgery, Harvard Medical School and Assistant Surgeon, Massachusetts General Hospital, who spoke on "Early Diagnosis of Carcinoma of the Cervix and the treatment in early cases."

Dr. Ulfelder emphasized the importance of carcinoma in situ, (an area of malignant epithelium in which no invasion can be demonstrated) because it is curable by total hysterectomy with preservation of ovary. The speaker pointed out that if child bearing is a possibility carcinoma in situ may be destroyed locally because cancer of the cervix invades slowly.

Treatment by surgery must be carried to the pelvic wall. He also stated that radiation treatment in the hands of some is good treatment.

The papers were discussed by Drs. Waterman and O'Connell.

The meeting adjourned at 10:15 p.m.

Attendance was 120.

Collation was served.

Respectfully submitted,

MICHEAL DIMAIO, M.D., *Secretary*

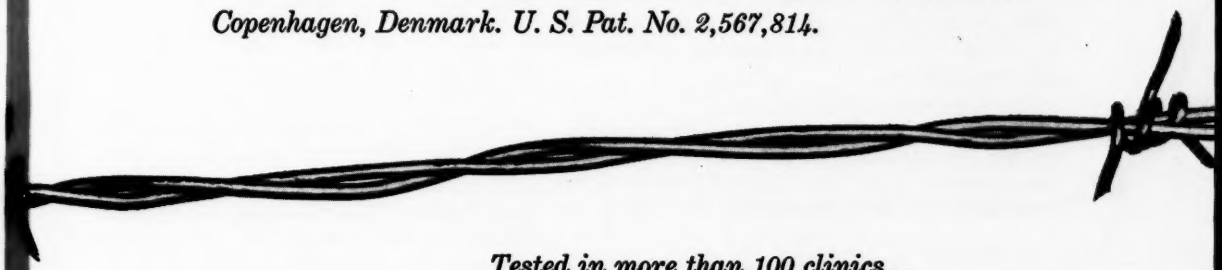
Much has been written about "Antabuse." Many alcoholics have long awaited its benefits.

Now, after nearly three years of intensive clinical research, it is available for prescription use.

"Antabuse" sets up a sensitizing effect to ethyl alcohol. It builds a "chemical fence" around the alcoholic . . . helps him develop a resistance to his craving. Its high degree of efficacy is confirmed by extensive clinical evidence.

"Antabuse" is safe therapy when properly administered. However, it should be employed only under close medical supervision. Complete descriptive literature is available and will be gladly furnished on request.

"Antabuse" is identical with the material used by the original Danish investigators, and is supplied under license from Medicinalco, Copenhagen, Denmark. U. S. Pat. No. 2,567,814.



Tested in more than 100 clinics . . .
by more than 800 qualified investigators . . .
on more than 5,000 patients . . . and covered by more than 200 laboratory and clinical reports.

"ANTABUSE"

. . brand of specially prepared and highly purified tetraethylthiuram disulfide.

Supplied in tablets of 0.5 Gm., bottles of 50 and 1,000.

rst, McKenna & Harrison Limited • New York, N. Y. • Montreal, Canada

RHODE ISLAND MEDICAL SOCIETY — NECROLOGY, 1951

ALVAH H. BARNES, M.D., who had practiced medicine in this city for the past 50 years, died at his home September 3, 1951, after a short illness. He was 79 years of age.

Dr. Barnes was a member of the Roger Williams General Hospital Staff and physician for the Priscilla Worsted Mills in Thornton. He was a long established member of the Rhode Island Medical Society.

EDWARD J. BLACK, M.D., was born January 15, 1881 and died on September 10, 1951, at the age of 70 years.

Dr. Black was graduated from Brown University in 1904 and Harvard University Medical School in 1908. He began his practice on Smith Street and for the past 26 years had maintained an office at 169 Angell Street.

Dr. Black was a member of the American Medical Association, the Rhode Island Medical Society, and the Providence Medical Association. He was also a member of the New England Section of the American Urological Association.

EDWARD S. BRACKETT, M.D., died on March 1, 1951, in his 75th year. He was born September 13, 1875 in Bridgeport, Connecticut, and he graduated from Yale University in 1897 and completed his studies at Yale Medical School in 1902, when he came to Providence, serving first as an interne and later a resident physician at Rhode Island Hospital.

His first office was on Elmwood Avenue, but for more than twenty years he was associated with the late Dr. Bertram H. Buxton at 167 Angell Street.

Dr. Brackett was the first president of the New England Obstetrical and Gynecological Association and, in the early 1930's, he was president of the Boston Obstetrical Society.

He was the first Chief of Staff of Lying-In Hospital when it was built in 1926, and, a short time later he became a co-chief of the gynecological service at Rhode Island Hospital.

Dr. Brackett was one of the founders of Blue Cross in Rhode Island, and at the time of his death was vice president of the Hospital Service Corporation of Rhode Island. He was a past president of the Providence Medical Association and the Rhode Island Medical Society, in 1936 was president of the Yale Association of Rhode Island, and in 1938 was president of the Rhode Island Birth Control League.

EDWARD F. BURKE, M.D., a practicing physician in Providence for 33 years, died Thursday, December 20 in St. Joseph's Hospital.

He was born in Stonington, Connecticut on April 19, 1881. He was graduated from Columbia University School of Pharmacy in 1905 and from Tufts Medical School in 1918. He was a past President of St. Joseph's Hospital and a member of the staff of Roger Williams General Hospital and Miriam Hospital. He was also a past President of Friendly Sons of St. Patrick and the Sons of Irish Kings.

He was a member of the Rhode Island Medical Society, the Providence Medical Association, and the American Medical Association. He was active in various committees of the local societies, serving as chairman of the air pollution committee of the Providence Medical Association at one time.

E. ALFRED CORMIER, M.D., of 465 Newport Avenue, Pawtucket, chief of staff of Notre Dame Hospital, Central Falls, died June 23, 1951, at Notre Dame Hospital.

He was born in Leicester, Massachusetts in June, 1893. He was a graduate of the public schools of that city, of Leicester Academy, of Assumption College, Worcester, and of Tufts Medical School.

His internship was served at St. Joseph's Hospital, Providence, and he opened his office in Pawtucket in 1921. He had been on the staff of the Notre Dame Hospital since 1922, serving as Chief of Staff since 1935.

He was a Fellow of the American College of Surgeons, a member and past president of the Pawtucket Medical Association, and a member of the Rhode Island Medical Society and the American Medical Association.

N. DARRELL HARVEY, M.D., 86, a past president of the Rhode Island Medical Society and a prominent ear, eye, nose and throat specialist in Providence for many years, died October 13, 1951 in New Rochelle, New York.

Dr. Harvey began his practice in Providence in 1892 immediately after finishing his medical training. He was a consulting specialist in a number of Rhode Island hospitals.

He was born in Halifax, N. S., July 31, 1864, and graduated from Dalhousie University and Halifax Medical College before going to New York in 1884 to study in the Columbia University medical department.

After his graduation there in 1888 he was at New York Hospital for 18 months and spent some time in specialization in his field before coming to Providence.

Dr. Harvey joined the Rhode Island National Guard as a first lieutenant and assistant surgeon of the First Infantry shortly after he came to the State. In 1896 he organized the Hospital Corps of Rhode Island.

With the outbreak of the Spanish-American War he was called to duty with his regiment as first assistant surgeon and served until after the fall of Santiago when he returned to Providence to resume his practice.

During World War I, with the assistance of the Providence Chapter of the American Red Cross and Rhode Island Hospital, he organized and led a relief party to Halifax after the disastrous explosion in its harbor. The Halifax Relief Committee, appointed by the Canadian government, later honored Dr. Harvey for his work in connection with the relief effort.

He held membership in the American Ophthalmological Society, the American Medical Association, the New England Ophthalmological Society, the American Academy of Ophthalmology and Oto-Laryngology, and in 1932 he was elected president of the Rhode Island Medical Society.

Dr. Harvey was consulting specialist in his field for 35 years at Rhode Island Hospital and he also served the Charles V. Chapin, Providence Lying-In, Pawtucket Memorial, Butler and Newport hospitals in a consulting capacity.

CHARLES E. V. KENNON, M.D. Long a member of the Rhode Island Medical Society and the Providence Medical Association, Dr. Charles E. V. Kennon, 90, died on April 18, 1951. He had been practicing medicine in Providence for 55 years before his retirement in 1940.

Dr. Kennon was born in Plymouth, Connecticut in 1860. He received his high school education at Andover Academy, and was graduated from Harvard Medical School in 1887. He was a contract doctor in the Spanish-American War, and he was on the staff of the Rhode Island Hospital. At one time he was chief medical examiner for the Metropolitan Life Insurance Company.

In 1947 Dr. Kennon was awarded the "Distinguished Service Award" by the Providence Medical Association.

Dr. Kennon was a former Secretary of the Providence Medical Association.

RICHARD F. McCOART, M.D., one of Rhode Island's leading industrial physicians, company doctor for numerous local manufacturing plants and a practicing physician in Olneyville for 36 years, died February 25, 1951. He was born October 14, 1890, in Rumford, and was graduated from East Providence High School.

Dr. McCoart began his medical career on graduation from the Tufts College Medical School in 1913. He was associated with St. Joseph's Hospital for a considerable time and was appointed one of the heads of the gynecology department in 1931.

He was on the staff of Roger Williams Hospital and was senior surgeon in the department of gynecology at St. Joseph's Hospital. He was a member of the Governor's Conference on Industrial Safety.

For 33 years he had served as company doctor at the Universal Winding Company, Cranston. From 1930 to 1934 he was visiting surgeon at the State Institutions, Howard. He also maintained a private practice in Olneyville Square for many years.

Dr. McCoart was president of the Rhode Island Industrial Physicians and Surgeons Association and was a member of both the American Association of Industrial Physicians and Surgeons and the New England Conference of Industrial Physicians and Surgeons.

He was a member of the Providence Medical Association and the Rhode Island Medical Society, the New England Obstetrical and Gynecological Society, and the American Medical Association.

HELEN C. PUTNAM, M.D., died at her home in Providence on February 2, 1951.

One of the oldest members of the Providence Medical Association, she was born September 14, 1857. She had an outstanding medical career. After graduation from Vassar College in 1878, she entered the Sargent School of Physical Education, then part of Harvard University, and then became Director of Physical Education at Vassar College. She received her M.D. from the Women's Medical College of Pennsylvania in 1889.

After completing her internship in the New England Hospital for Women and Children in Boston, Dr. Putnam came to Providence in 1892 to specialize in gynecology. She also took much interest in pediatrics, especially in child hygiene, and in general medicine, practicing her profession in Providence for over 43 years. She was a leader in health education and public welfare. An honorary LL.D. degree was awarded her in 1913 by Western Reserve University, and her list in "Who's Who in America" is a very distinguished record of honorary and active membership in many local and national organizations. She served as editor in the department of Child Hygiene in *Child Welfare* from 1909 to 1915.

WILLIAM CAMPBELL THOMPSON, M.D., died in Westerly, Rhode Island on March 18, 1951.

A member of the Rhode Island Medical Society and the Providence Medical Association since 1941, Dr. Thompson was 74 years of age.

His preliminary education was gained in the public schools of Westerly. He was graduated from Flower & 5th Avenue Hospital in New York in 1903. His internship was served at the Metropolitan Hospital, New York City, and he was on the active staff of the Westerly Hospital for fifteen years. He had been President of the visiting staff of the Westerly Hospital, Secretary and Treasurer of the Westerly Hospital, President, Secretary, and Treasurer of the Westerly Medical Society.

He was a member of the Courtesy Staff of the South County Hospital in Wakefield, Rhode Island, and the Lawrence Memorial Hospital in New London, Connecticut.

He was a member of the American Geriatric Society, and was 1st Vice President of the South County Medical Society.

ANGELO SCORPIO, M.D., physician and surgeon, with offices at 183 Angell Street, Providence, died on November 14 at the age of 55. He was born in Providence on September 12, 1896 and attended the Providence public schools. After graduation from Classical High School, he entered R. I. State College, graduating in 1922 with the degree of Bachelor of Science.

He attended Brown University the following year where he received his master's degree in science. He then entered Harvard Medical School where he was awarded his M.D. in 1927.

He served his internship at the surgical department of the Union Memorial Hospital, Baltimore, and began the practice of medicine in 1928 in Providence.

He served on the surgical staff of the out-patient department at Rhode Island Hospital and was assistant surgeon at the State Infirmary.

Dr. Scorpio was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association, and a month prior to his death he was elected a Fellow of the American College of Surgeons.

CLINTON STEVENS WESTCOTT, M.D., a practicing physician here for forty-five years, died January 8, 1951.

Born in Providence, April 16, 1877, Dr. Westcott was educated in the local public schools and attended Worcester Academy. He completed his medical course at the College of Physicians and Surgeons at Columbia University, New York City, in 1901, and for the following two years was an intern at Rhode Island Hospital. In 1918-19 he was a lieutenant in the Navy Medical Corps.

After acting as a visiting physician at Rhode Island Hospital for many years, Dr. Westcott was made physician-in-chief of the department of medicine there in 1934. He was a member of the American Medical Association and the Rhode Island Medical Society, and president of the Providence Medical Association in 1930-31.

PERMANENT HEALTH RECORD BOOKLET FOR NEWBORN OF PROVIDENCE

BEGINNING January 1, 1952, the Health Department of the City of Providence will present each child born in the city, a Health Record Booklet in addition to its birth certificate. This form will be a sixteen page booklet which will contain pertinent information relative to the child's birth, space for its medical history for the first, second, third and fourth year of life, a separate page for the results of the pre-school examination and pages for the results of the school examination with special places for specific defects and remarks. In addition there are several pages for notes to be filled in by the physician or nurse. Of necessity, this booklet had to be condensed. However, where certain items need be expanded upon the physician will find it convenient to use the space for remarks, either general remarks or under Health notes.

In order for this booklet to prove of value, it is necessary that full cooperation be had of every physician as well as the cooperation of the parents. It will therefore be necessary for the physician in attendance at the birth to complete and sign the record on the pregnancy and the delivery. If the pregnancy was normal, only a check mark after "Yes" is required; however, if the pregnancy was not normal, the abnormal diagnosis may be put down and if further explanation is needed, the health notes may be used. Similarly one or two words can be used to describe the delivery. Under anesthesia used, the type and nature of anesthesia should be stated.

The record of the child's first year of life will show the immunizations given and illnesses. If the illnesses are of a contagious nature they will also be found under the record of illness. Should anything special in the general development of the child appear, the information could be placed immediately into the record, either in the space for general development for the first year of life or under preschool health notes or Health notes, otherwise the physician in general attendance of the child for his first year of life can simply summarize the general development under the space provided in the first year of life.

Similarly the spaces for the second, third and fourth years can be utilized by the attending physician or pediatrician.

From analysis of the records of Smallpox vaccinations performed at the Health Department Clinics and the number of children entering schools and from the analysis of the record of immunization done at the Health Department clinic and from a study of the results of Schick Tests in the schools, it would seem that better than 85% of all children in the City of Providence have private family physicians or pediatricians. Such a relationship should be encouraged and it is the hope and desire of the Health Department that everything be done to maintain and improve such relationship. The proper cooperation of the Medical Profession in maintaining the health record form will greatly assist in this program, with the result that in another five or six years it will become possible to discontinue the routine health examinations in schools and substitute instead a routine physical examination by the child's own private physician. While it is true that in the past, routine physical examinations of school children greatly assisted in the control of communicable diseases, it must be recognized that such control is no longer necessary and that the continuation of the routine physical examination with its expansion to hearts and lungs has not proven to be of the value originally intended. Instead said school examination has only given thought to some that it is the state's duty and function to provide medical care to the people in general. The fallacy of socialized medicine need not be dwelt on here. It is hoped that proper use of the health record form will tend to stimulate and improve the patient-physician relationship, with the general practitioner, the pediatrician, and the specialist, each making his own pertinent observation as required on this Health Record Form. It is our hope and belief that in later life this record will prove of inestimable value both to the patient and to his physician.

IMPORTANT ANNOUNCEMENTS

See Pages 24 - 62 - 64

COMPONENT SOCIETIES BY MEDICAL DISTRICTS — 1952

SOCIETY	DELEGATES	COUNCILLOR	OFFICERS	MEETING
Kent County Medical Society	Stanley Davies Peter Erinakes	Arthur Hardy	*President*, Edmund Hackman *V. Pres.*, Irene Maynard *Secretary*, Briand Beaudin *Treasurer (protem)* Joseph Wittig	3rd or 4th Tuesday of each month
Newport County Medical Society	Frank Logler Donald B. Fletcher	Samuel Adelson	*President*, Henry W. Brownell *1st Vice Pres.*, Robert L. Bestoso *2nd Vice Pres.*, John M. Malone *Secretary*, Osmond Grimes *Treasurer*, Norbert Zielinski	4th Tuesday of every other month, starting September
Pawtucket Medical Association	James P. Healey Henry J. Hanley Henry E. Turner Edward E. Trainor Duncan H. C. Ferguson	Earl J. Mara	*President*, Kieran Hennessey *Vice Pres.*, Laurence Senseman *Secretary*, Hrad H. Zolmian *Treasurer*, Harold A. Woodcome	3rd Thursday of every month
Washington County Medical Society	Louis Morrone Samuel Nathans	John P. Jones	*President*, Albert C. Henry *Vice Pres.*, Julianna Tatum *Secretary*, Samuel Farago *Treasurer*, Samuel Farago	2nd Wednesday of every 3 months, starting Oct.
Bristol County Medical Association	Charles Dunbar	Charles E. Millard	*President*, Charles E. Millard *Vice Pres.*, E. Paul Bruno *Secretary*, Charles W. Dunbar *Treasurer*, Robert E. Drew	3rd Tuesday of each month
Woonsocket Medical Society	Victor H. Monti Saul Wittes	Alfred King	*President*, G. A. Crepeau *Vice Pres.*, Emil Kaskiw *Secretary*, Euclide L. Tremblay *Treasurer*, Paul Boucher	No fixed date
Providence Medical Association	Charles J. Ashworth Robert Baldridge J. Murray Beardsley Frederic J. Burns Francis H. Chafee Peter P. Chase Frank B. Cutts	Frank Dimmitt William P. Davis Donald DeNyse John Dillon Michael DiMaio William J. Fischer David Freedman Herman Grossman	*President*, Frederic J. Burns *Vice Pres.*, Alfred L. Potter *Secretary*, Michael DiMaio *Treasurer*, Robert G. Murphy Peter Harrington William Horan Russell Hunt Louis I. Kramer Herman A. Lawson Edward McLaughlin Daniel Troppoli	1st Monday of every month; Oct.-April inclusive Robert Murphy John Myrick J. C. O'Connell E. O'Reilly A. L. Potter Louis Sage George W. Waterman

SOCIETY	OFFICERS	ANNUAL MEETING
Rhode Island Medical Society 1951-52	*President*, Herman A. Lawson *Vice Pres.*, Edward S. Cameron *Pres. Elect.*, Albert H. Jackvony *Secretary*, Morgan Cutts *Treasurer*, Earl F. Kelly *Ass't Treas.*, John A. Dillon	May 6, 7, 8, 1952 at Rhode Island Medical Society Library, 106 Francis Street Providence 3, R. I.

CHAIRMAN, STANDING COMMITTEES	
Peter P. Chase	Scientific Work and Annual Meeting
Charles L. Farrell	Public Policy and Relations
James H. Fagan	Public Laws
Marshall Fulton	Postgraduate Education
Eske Windsberg	Medical Economics
Stanley Sprague	Industrial Health
Irving A. Beck	Library
John E. Donley	Publications
Robert T. Henry, John P. Jones	Auditors

PHYSICIANS DIRECTORY

ANESTHESIOLOGY

EDWARD DAMARJIAN, M.D.
124 Waterman St., Providence 6
GAspee 1-1808
Nerve Block
Diagnostic and Therapeutic

CARDIOLOGY

CLIFTON B. LEECH, M.D.
(Diplomate of American Board of Internal Medicine; Internal Medicine and Cardiovascular Disease)
Practice limited to diseases of the heart and cardiovascular system.
82 Waterman Street, Providence
Hours by Appointment OFFICE: Gaspee 1-5171
RESIDENCE: Warren 1-1191

DERMATOLOGY

WILLIAM B. COHEN, M.D.
Practice limited to
Dermatology and Syphilology
Hours 2-4 and by appointment - GA 1-0843
105 Waterman Street Providence, R. I.

VINCENT J. RYAN, M.D.
Practice limited to
Dermatology and Syphilology
Hours by appointment Call GA 1-4313
198 Angell Street, Providence, R. I.

BENCEL L. SCHIFF, M.D.
Practice limited to
Dermatology and Syphilology
HOURS BY APPOINTMENT
Pawtucket 5-3175
251 Broadway, Pawtucket, Rhode Island

ARTHUR B. KERN, M.D.
Practice Limited to
Dermatology and Syphilology
Hours by appointment • Phone DE 1-6183
247 Waterman Street Providence 6, R. I.

DERMATOLOGY

MALCOLM WINKLER, M.D.
Practice limited to
Dermatology and Syphilology
Hours by appointment Call DExter 1-0105
199 Thayer Street, Providence, R. I.

EYE, EAR, NOSE AND THROAT

NATHAN A. BOLOTOW, M.D.
Ear, Nose and Throat
Otorhinologic Plastic Surgery
Hours by appointment GAspee 1-5387
126 Waterman Street Providence 6, R. I.

FRANCIS L. BURNS, M.D.
Ear, Nose and Throat
Office Hours by appointment
382 Broad Street Providence

JAMES H. COX, M.D.
Practice Limited to Diseases of the Eye
By Appointment
141 Waterman Street Providence 6, R. I.
GAspee 1-6336

JOS. L. DOWLING, M.D.
Practice limited to
Diseases of the Eye
57 Jackson Street Providence, R. I.
1-4 and by appointment

HERMAN P. GROSSMAN, M.D.
Practice limited to Diseases of the Eye
By appointment
210 Angell Street Providence 6, R. I.
DExter 1-2433

RAYMOND F. HACKING, M.D.
Practice limited to Diseases of the Eye
105 Waterman Street Providence 6, R. I.

F. CHARLES HANSON, M.D.
Specializing in Eye
162 Angell Street CALL GAspee 1-9234
Providence 6, R. I. or JAckson 1-2331

THOMAS R. LITTLETON, M.D.
Ear, Nose and Throat
Office Hours by Appointment
204 Angell Street Providence 6, R. I.
Phone GAspee 1-2650

EYE, EAR, NOSE AND THROAT

BENJAMIN FRANKLIN TEFFT, M.D.
Ear, Nose and Throat
185 Washington Street West Warwick, R. I.
Hours by appointment Valley 1-0229

HERMAN A. WINKLER, M.D.
Ear, Nose and Throat
224 Thayer Street, Providence, R. I.
Hours by appointment Call GAspee 1-4010

MILTON G. ROSS, M.D.
Practice limited to Diseases of the Eye
Office Hours by Appointment
355 Thayer Street Providence 6, R. I.
GAspee 1-8671

NATHANIEL D. ROBINSON, M. D.
Practice limited to Diseases of the Eye
Office Hours by Appointment
112 Waterman Street Providence 6, R. I.
TEmple 1-1214

NEURO—PSYCHIATRY

DAVID J. FISH, M.D.
Neuropsychiatry
355 Thayer Street
Providence 6, R. I.
JAckson 1-9012 Hours by appointment

HUGH E. KIENE, M.D.
Neuro-Psychiatry
113 Waterman Street Providence 6, R. I.
Telephone: Plantations 1-5759
Hours: By appointment

PROCTOLOGY

THAD. A. KROLICKI, M.D.
Practice Limited to Diseases of Anus, Rectum and Sigmoid Colon
Hours by appointment
102 Waterman Street, Providence, R. I.
Call JAckson 1-9090

PSYCHIATRY

GERTRUDE L. MULLER, M. D.
Psychiatry
193 University Ave., Providence 6, R. I.
Hours by Appointment Only
Doctor may be reached after 5 p.m. daily, and weekends, at DExter 1-5398

CHECK YOUR INSURANCE POLICY!

Check Your Insurance Policy!

If you plan any vacation trip outside the continental United States, other than to Canada, check your insurance policies to make sure that you have coverage, particularly as regards health and accident provisions. Most policies require a special permission, to be secured from the insurance company, to extend the protection of the person while he is travelling in Mexico, the West Indies, Europe, etc. In all cases it is recommended that you read your insurance policies carefully before making any trips.

FACTS ABOUT A.M.A. DUES FOR 1952

1. American Medical Association membership dues for 1952 are $25.00.

2. Fellowship dues for 1952 have been abolished.

3. American Medical Association membership dues are levied on "active" members of the Association. A member of a constituent association who holds the degree of Doctor of Medicine or Bachelor of Medicine and is entitled to exercise the rights of active membership in his constituent association, including the right to vote and hold office as determined by his constituent association, and has paid his American Medical Association dues, subject to the provisions of the By-Laws, is an "active" member of the association.

4. American Medical Association membership dues are payable through the component county medical society or the constituent state or territorial medical association, depending on the method adopted locally.

5. Commissioned medical officers of the United States Army, the United States Navy, the United States Air Force or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration, who have been nominated by its Chief Medical Director, may become Service Fellows on approval of the Judicial Council. Service Fellows need not be members of the component county or constituent state or territorial associations or the American Medical Association. They do not receive any publication of the American Medical Association except by personal subscription. If a local medical society regulation permits, a Service Fellow may elect to become an active member of a component and constituent association and the American Medical Association, in which case he would pay the same membership dues as any other active member and received a subscription to *The Journal of the American Medical Association.*

6. An active member of the American Medical Association may be excused from the payment of American Medical Association membership dues when it is deemed advisable by the Board of Trustees, provided that he is partially or wholly excused from the payment of dues by his component society and constituent association.

The following may be excused in accordance with this provision: (a) members for whom the payment of dues would constitute a financial hardship as determined by their local medical societies; (b) members in actual training but not more than five years after graduation from medical school; (c) members who have retired from active practice; (d) members who have reached the age of 70, on request, and starting January 1 following the 70th birthday, and (e) members who are called to active duty with the armed forces (exemption begins July 1 or January 1 following entrance on active duty). The last two categories are excused from A.M.A. dues regardless of local dues exemptions.

7. Active members of the American Medical Association are not excused from the payment of American Medical Association membership dues by virtue of their classification by their local societies as "honorary" members or because they are excused from the payment of local and state dues. Active members may be excused from the payment of American Medical Association membership dues only under the provision described in Paragraph 6 above.

8. American Medical Association membership dues include subscription to *The Journal* of the American Medical Association. Active members of the Association who are excused from the payment of dues will not receive *The Journal* except by personal subscription at the regular subscription rate of $15.00 a year.

9. Members may substitute one of the special journals published by the Association for *The Journal* to which they are entitled as members.

10. A member of the American Medical Association who joins the Association on or after July 1 will pay membership dues for that year of $12.50 instead of the full $25.00 membership dues.

11. An active member is delinquent if his dues are not paid by June 1 of the year for which dues are prescribed and shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after the notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

12. Members of the American Medical Association who have been dropped from the Membership Roll for nonpayment of annual dues can not be reinstated until such indebtedness has been discharged.

13. The apportionment of delegates from each constituent association shall be one delegate for each thousand (1,000), or fraction thereof, *active members of the American Medical Association* as recorded in the office of the Secretary of the American Medical Association on December 1 of each year.

DIATHERMY REGULATIONS

CHARLES P. WILLIAMSON, ESQ.

Legal Counsel to the R. I. Medical Society

IN VIEW of the number of requests for clarification of the current regulations of the Federal Communications Commission governing the use of medical diathermy equipment, I have endeavored to digest these with the thought that the summary might be of interest to others in the medical profession.

The regulations were printed in part in the August 1950 issue of your Medical Journal. The entire text appears as Section 18 of Title 47 of the Code of Federal Regulations commencing at page 466. These regulations are technical and complicated and reference to the complete text is recommended especially if there is a question concerning radiation or intensity measurement tests for your equipment.

Generally, a station license is not required for the operation of medical diathermy equipment if the operation is confined to one or more of the following frequencies:

Center Frequency of Channel	*Tolerance from Center Frequency*
13,560 kc.	(plus or minus 6.78 kc.)
27,120 kc.	(plus or minus 1.60 kc.)
40,680 kc.	(plus or minus 20 kc.)

The additional frequency of 2450 Mc (plus or minus 50 Mc) has been made available by order dated December 26, 1946 subject to the same conditions as applicable to use of the above frequencies.

Prior to July 1, 1952 use of equipment on frequencies other than those listed above should be discontinued if such use interferes with local radio or television reception or if "spurious and harmonic" radiation is not suppressed so that such will not exceed the strength of 25 microvolts per meter at a distance of 1,000 feet from the equipment.

Even if you have equipment of the type approved by the Commission, you must have available a certificate from either the manufacturer or a competent engineer describing the equipment and the conditions under which it should be operated and certifying that it can meet requirements of the regulations for a period of at least three years. Use of equipment of a type not approved by the Commission, even though on the above frequencies, is conditioned on the owner or operator securing a certificate from a competent engineer or the manufacturer containing the same information as required on approved equipment and, in addition, a statement of the engineering tests upon which the certification is based; renewal of a certificate on equipment which has not received type approval must be renewed each three years.

After July 1, 1952, use of equipment on other than the prescribed frequencies *must* be discontinued unless the owner or operator complies strictly with the provisions spelled out in Section 18.12 of the FCC regulations. These can, perhaps, be summarized as follows:

(a) Your equipment must be provided with a rectified and filtered plate power supply, power line filters and operated in a completely shielded room;

(b) the emission of radio frequency energy generated by your equipment must not exceed a strength in excess of 15 microvolts per meter at a distance of 1,000 feet or more from your equipment;

(c) a certificate must be obtained from a competent engineer (or manufacturer) setting forth the conditions on which your equipment is operated and certifying that under the described conditions of operation the requirements of the regulations may reasonably be excepted to be met for a period of at least three years. Field intensity measurements in such tests are to be made strictly in accordance with these regulations; and

(d) the certificate shall be renewed every three years.

It is my understanding that uncontrolled shortwave diathermy apparatus cannot be changed economically to meet the rules and regulations of the Federal Communications Commission. It is possible for a qualified engineer to redesign the equipment, but the cost of labor and materials and the expense of having a representative of the Federal Trade Commission or an authorized engineer examine it would be in most cases more than would be involved in the purchase of a new apparatus from a reliable manufacturer.